

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03864

CERTIFICATE OF DEATH

03864

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac Manor Rest Home</u>		d. STREET ADDRESS <u>Potomac Manor Rest Home</u>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>E.</u> Last <u>ADAMS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/80</u>
9. AGE (in years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-54-4217</u>	
17. INFORMANT <u>Potomac Manor Rest Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - Acute -</u> <u>4201</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Date</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>Jan.</u> , 19 <u>66</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John G. Ball</u>		22b. DATE SIGNED <u>3/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		22d. ADDRESS <u>Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3/15/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike, Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE			

MAR 16 1966

03883

THE UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

FOURTH DISTRICT

ALBUQUERQUE, NEW MEXICO

TO: DIRECTOR, BUREAU OF LAND MANAGEMENT

FROM: SAC, ALBUQUERQUE

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03875					03865						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Montgomery</b>					a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kensington Gardens Nursing Home</b>					d. STREET ADDRESS <b>7313 Lynhurst Street</b>						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First Middle Last <b>SYDNEY TINSLEY ALEXANDER</b>					Month Day Year <b>Mar. 22, 19 66</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 29, 1880</b>		9. AGE (In years last birthday) <b>85</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>2 23</b>			
13. FATHER'S NAME <b>William Taylor</b>					14. MOTHER'S MAIDEN NAME <b>Martha Holland</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>219-34-8181A</b>						
17. INFORMANT <b>Daughter</b>					Address <b>Mrs. Sydney T. Jones Same as Item 2.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1948</b> , 19 <b>22</b> Mar, 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>22 March 19 66</b> , and that death occurred at <b>5:40 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John M. Wyman</b>					22b. DATE SIGNED <b>3-23-66</b>						
22c. PHYSICIAN'S NAME (Type) <b>JOHN M. WYMAN</b>					22d. ADDRESS <b>7801 Norfolk Ave., Bethesda, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3-24-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Natl. Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Falls Church, Virginia</b>				
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>					ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03876

CERTIFICATE OF DEATH

03866

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>XXXXXX XXXXXX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 1/2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hosp.</u>				d. STREET ADDRESS <u>250 Farragut St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Oscar</u> Last <u>Allison</u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1966</u>		5. SEX <u>M</u>		6. CDR DR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-95</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John S. Allison</u>		14. MOTHER'S MAIDEN NAME <u>Elfrida Holmes</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW#1</u>			
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Elmer E. Allison</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Heart Block</u> <u>4201</u> DUE TO (b) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis, Brain Damage</u> 20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 15, 1966</u> to <u>Mar 15, 1966</u> that (I) (we) last saw the deceased alive on <u>Mar 15, 1966</u> and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>John J. Curry</u>		22b. DATE SIGNED <u>3/15/66</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>SAH Hargreaves</u>		25a. REC'D BY REGISTRAR <u>MAR 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		26. ADDRESS <u>2901 14th NW</u>	

Cleared with Dr. Ross, Medical Examiner

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

<div>28</div> <div>1</div> <div>(M)</div> <div>03897</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>03867</div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DE</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WAKOMA PARK</u>						c. LENGTH OF STAY IN lb <u>4 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SAN. &amp; HOSP.</u>						d. STREET ADDRESS <u>1433 Manchester Lane NW</u>					
3. NAME OF DECEASED (Type or print) <u>ETHEL L. Farrie Anderson</u>						4. DATE OF DEATH Month <u>MARCH</u> Day <u>27</u> Year <u>1966</u>					
5. SEX <u>FE</u>		6. COLOR OR RACE <u>WH</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/9/92</u>		9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst.</u>						11b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>James McGrannahan</u>						14. MOTHER'S MAIDEN NAME <u>Eva Law</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec.</u> , 19 <u>53</u> , to <u>3-27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-27</u> 19 <u>66</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Scruch T. Kimble</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Scruch T. Kimble</u>						22d. ADDRESS <u>927 Pershing Dr. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>						23b. DATE THEREOF <u>3/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery Prince Georges County, Md.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>The S.H. Hine</u> ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> Md.			
DATE <u>MAR 29 1966</u>											

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Handwritten text, possibly a signature or name, appearing in the center of the page.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03878 CERTIFICATE OF DEATH 03868									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>37 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG,</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>					d. STREET ADDRESS <b>ROUTE 2</b>				
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>HAZEL</b> Last <b>BLANKENSHIP BAILEY</b>					4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/13/1916 1917</b>		9. AGE (In years last birthday) <b>50</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL BLANKENSHIP</b>					14. MOTHER'S MAIDEN NAME <b>HELEN BAILEY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MONTGOMERY GENERAL HOSPITAL</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>6000 Congestive heart failure</b> DUE TO (b) <b>Water intoxication</b> DUE TO (c) <b>Chronic pyelonephritis</b>									INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 wk.</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Severe Obesity, Diabetes mellitus, thrombophlebitis, ASCVD</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 2, 1966</b> to <b>Mar. 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>Mar. 4, 1966</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Frederick Moqmau</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Mar. 5, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK MOQMAU, M. D.</b>					22d. ADDRESS <b>SANDY SPRING MEDICAL CENTER</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-8-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>True Gospel</b>		23d. LOCATION (City, town or county) (State) <b>Lisbon, Md.</b>			
24. FUNERAL DIRECTOR <b>Francis H. Barber Funeral Home</b>		ADDRESS <b>Laytonsville</b>		Md.		25a. REC'D BY REGISTRAR <b>MAR 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

03888

19 XXXX 1917

Home

H. Wils

Lisbon, Md.

True Gospel

3-7-00

Burial

Francis H. Barber - Mineral H. - Laytonville Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03879

CERTIFICATE OF DEATH

03869

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>16 Kentbury Way</b>		d. STREET ADDRESS <b>16 Kentbury Way</b>	
3. NAME OF DECEASED (Type or print) <b>ADELBERT R. BAKER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1901</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FBI Govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>DeForrest Baker</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Ranier</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-44-4550</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Aneurysm</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 min</b> <b>Unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 3, 1966</b> , to <b>March 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 4, 1966</b> , and that death occurred at <b>7:20 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John D. Herman</b>		22b. DATE SIGNED <b>3-7-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. HERMAN, M.D.</b>		22d. ADDRESS <b>4801 Montgomery Lane, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-8-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Montgomery County, Md.</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 8 1966</b>	

4535

Model W-1000-01-015

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**03880**

## CERTIFICATE OF DEATH

**03870**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN lb <u>50 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>5521 North 17th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Finley</u> Last <u>BALDWIN</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>9</u> Year <u>19 66</u>			
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Cauc.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 28, 1915</u> 9. AGE (In years lost birthday) yrs. <u>50</u>		IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Congressman, U.S. House Rep.- Government</u> 10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Oakland, Calif.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John F. Baldwin, Sr.</u> 14. MOTHER'S MAIDEN NAME <u>Nellie Linekin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Worldwar 2</u> 16. SOCIAL SECURITY NO. <u>545 016 766</u>		17. INFORMANT <u>Mrs. Mary I. Baldwin</u> Address <u>Arlington, Va. 5521 North 17th St./</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma stomach, with generalized metastases</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that <del>(I)</del> (this hospital) attended the deceased from <u>Jan. 17</u> , 19 <u>66</u> to <u>Mar. 9</u> , 19 <u>66</u> that <del>(I)</del> (we) last saw the deceased alive on <u>Mar. 9</u> , 19 <u>66</u> , and that death occurred at <u>1008M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (Type) <u>D. P. Osborne, M. D.</u>				22b. DATE SIGNED <u>Mar. 10, 1966</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Removal</u>		23b. DATE THEREOF <u>3-12-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakmont Memorial Park</u>			
23d. LOCATION (City or Town) <u>Lafayette</u> (County) _____ (State) <u>California</u>		24. FUNERAL DIRECTOR <u>Joseph Gawler &amp; Sons, 5130 Wisconsin Ave., N.W., Washington, D. C.</u>					
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Ball, Medical Exam., Montgomery Co., notified and will approve.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03881					03871				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Montgomery					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highpoint					b. COUNTY Montgomery				
c. LENGTH OF STAY IN 1b Years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highpoint				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6001 Massachusetts Avenue					d. STREET ADDRESS 6001 Massachusetts Avenue				
3. NAME OF DECEASED (Type or print) First MIDDLE Last JUANITA AYERS BARIDON					4. DATE OF DEATH Month Day Year March 16 1966				
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/16/08		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Ayers					14. MOTHER'S MAIDEN NAME Molla Melton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 579-36-0143		17. INFORMANT Mrs. Dixie Gildon - Same as item #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1550 general carcinomatosis DUE TO (b) primary carcinoma of lung DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH months 18 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Sept 1965, to 3-16, 1966, that (1) (we) last saw the deceased alive on 2-11 1966, and that death occurred at 8 A.M. from the causes and on the date stated above.									
22a. SIGNATURE R. M. Tilley, Jr.						22b. DATE SIGNED 3-16-66		22c. PHYSICIAN'S NAME (Type) R. M. Tilley	
22d. ADDRESS 4701 Mass. Ave., NW, Wash., D.C.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/19/66		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery			23d. LOCATION (City, town or county) (State) Culpepper, Virginia		
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Washington, D.C.						25a. REC'D BY REGISTRAR MAR 21 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	





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1 (M)

Curried to Dr. Deep J. Huggler

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03882

03872

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>2102 Dayton St.</u>	
3. NAME OF DECEASED (Type or print) <u>L. George XXXXX Bartlett</u>		4. DATE OF DEATH <u>March 6 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fed. Government Retired.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>L. George XXX Bartlett</u>		14. MOTHER'S MAIDEN NAME <u>XX Huggler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>220-38-1276</u>	
17. INFORMANT <u>Louise P. XXX Bartlett</u>		Address <u>2102 Dayton St. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION Acute</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY THROMBOSIS</u> (c) <u>13 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 11, 1965</u> to <u>Mar 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>Mar 6, 1966</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip E. Jones</u>		22b. DATE SIGNED <u>3-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones MD.</u>		22d. ADDRESS <u>800 Pershing Drive Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 9, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George's Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Annexed. Government. 1914

James G. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03888

CERTIFICATE OF DEATH

03873

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN 1b <u>71 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dumfries</u>		d. STREET ADDRESS <u>P. O. Box 22</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nona</u> Middle <u>(N)</u> Last <u>Bartley</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 July 1906</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dayton, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>McIntire</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Harry H. Bartley</u>		<u>1736 Columbia Road, N.W. Washington, D. C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma of the Uterus</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>Dec. 23</u> , 19 <u>65</u> , to <u>March 4</u> , 19 <u>66</u> that <u>(X)</u> (we) lost saw the deceased alive on <u>March 4</u> , 19 <u>66</u> , and that death occurred at <u>5:18 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Joel E. Winker</u>		22b. DATE SIGNED <u>March 5, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joel E. Winker, M.D.</u>		22d. ADDRESS <u>U. S. Naval Hospital Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 8, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>R. A. Pumphrey,</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 8 1966</u>	
<u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13333

13333

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03884

03874

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8509 Woodhawn Blvd. Bethesda, Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Chevy Chase Nursing and Conv. Center</u>				d. STREET ADDRESS <u>15-1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Barton</u> Last <u>Barton</u>				4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 4, 1879</u>		
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Byron Allison</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Hine</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thermin RN</u>			
					Address <u>Chevy Chase Nursing Center</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular atherosclerosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1964, to <u>3-29</u> , 1966, that (I) (we) last saw the deceased alive on <u>2-26-1966</u> , and that death occurred at <u>2:57</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>Stephen W. DeJeter</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-29-1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN W. DEJETER, M.D.</u>				22d. ADDRESS <u>6719 WILSON LANE, BETHESDA, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda, Md</u>		
24. FUNERAL DIRECTOR <u>Chevy Chase funeral home</u>				ADDRESS <u>5101 WILSON AVE</u>		25a. REC'D BY REGISTRAR <u>APR 4 1966</u>		
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





03885

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03875

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN TB <b>10 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital</b>				d. STREET ADDRESS <b>3308 PERRY AVE</b>			
3. NAME OF DECEASED (Type or print) <b>AVA</b> <b>KIOLA</b> <b>BASILE</b>				4. DATE OF DEATH Month <b>3</b> Day <b>14</b> Year <b>1966</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-31-16</b> <b>49</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED.</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>15</b> Days <b>1</b>	
11. BIRTHPLACE (State or foreign country) <b>MATIAS W. Va.</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>Albert May</b>				14. MOTHER'S MAIDEN NAME <b>EFFIE Cullers.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Theda Courville, Pasadena, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia secondary to extensive burns,</b> <b>9160</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>30% body area, accidental.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased using cleaning fluid, burned when it ignited as she smoked cigarette.</b>			
20c. TIME OF INJURY Hour a.m. <b>11:00</b> <b>3/4</b> 19 <b>66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Kensington Montg. Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3-17-1961</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Glenn Haven Memorial Pk.</b>				22d. LOCATION (City, town, or county) <b>Glenn Haven Md.</b> (State)			
23. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>				24a. REC'D BY REGISTRAR <b>Charles Judge</b>			
24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				MAR 21 1966			

5360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. LENGTH OF STAY IN 1b <u>17 years</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>707 Silver Spring Ave.</u>						e. STREET ADDRESS <u>707 Silver Spring Ave.</u>					
3. NAME OF DECEASED (Type or print) <u>AMOS WARD BEALL</u>						4. DATE OF DEATH <u>MARCH 7 1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12, 1876</u>		9. AGE (In years last birthday) <u>89 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
				WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired steam-fitter</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>217-20-7712</u>		17. INFORMANT <u>Alice Beall</u> Address <u>707 Silver Spring Ave. Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA.</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (u) (this hospital) attended the deceased from <u>JULY 1960</u> , to <u>MARCH 7, 1966</u> , that (we) last saw the deceased alive on <u>MARCH 7 1966</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>James R. Coleman MD.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-7-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>						22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING, MARYLAND.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>March 10, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Avenue</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE					
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>						DATE <u>MAR 10 1966</u>					

MEDICAL CERTIFICATION

113028

13333

WARD BENT

BAKCHORHOMONIA

JAMES R. COLEMAN  
JAMES R. COLEMAN MD  
March 7th

PAUL COLEMAN MD

MAR 10 1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03887

CERTIFICATE OF DEATH

03877

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>New Born.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bermentown</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>Rt 1 Box 25 Blunt Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Bay Beckwith</u>		4. DATE OF DEATH Month Day Year <u>March 26 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 24 1966</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>1 18 42</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland - Montgomery</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Harold M. Beckwith</u>	
14. MOTHER'S MAIDEN NAME <u>Edmonds</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harold M. Beckwith (father)</u> Address <u>OK.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination, intraabdominal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture Liver, spontaneous</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>@ 5 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>birth</u> , 19 <u>66</u> , to <u>3/26/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/23/65</u> , and that death occurred at <u>12:55</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>J. W. Stohlman M.D.</u>		22b. DATE SIGNED <u>3/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. W. STOHLMAN M.D.</u>		22d. ADDRESS <u>4711 CHASE AVE. BETHESDA MD 20014</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-27-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley cemetery, Clarksburg, Ma.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Robert L. Sworden</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 29 1966</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

17280

DEPARTMENT OF CLARK

17280

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DEPARTMENT OF CLARK

DEPARTMENT OF CLARK

DEPARTMENT OF CLARK



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03888

03878

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10411 Huntley Ave.,</b>		d. STREET ADDRESS <b>10411 Huntley Ave.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Bellafiore</b> Last <b>Bellafiore</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 July 1900</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Salvatore Bellafiore</b>	
14. MOTHER'S MAIDEN NAME <b>Filipa Marasia</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Adelaide J. Bellafiore wife</b> Address <b>2a, b, c, d above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastases</b> <b>177X</b> DUE TO <b>Adenocarcinoma of the prostate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>June</b>	20f. (City or town) (County) (State) <b>March 66</b>
21. I certify that (I) (this hospital) attended the deceased from <b>June 1965</b> to <b>March 1966</b> , that (I) (we) last saw the deceased alive on <b>March 4 1966</b> , and that death occurred at <b>10:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Daniel L. Hayes</b>		22b. DATE SIGNED <b>March 5, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Daniel L. Hayes</b>		22d. ADDRESS <b>8218 Wisconsin Ave. Bethesda Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9 Mar. 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Md.</b>
24. FUNERAL DIRECTOR <b>Rinaldi Funeral Home, Inc. 7400 Georgia Ave.</b>		25a. REC'D BY REGISTRAR <b>MAR 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18328

18328

STATE OF NEW YORK  
IN SENATE  
January 10, 1900.  
REPORT  
OF THE  
COMMISSIONERS OF THE  
LAND OFFICE  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE  
MAY 1, 1899.  
ALBANY:  
J. B. LEECH, PRINTERS.  
1900.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03889

03879

1. PLACE OF DEATH a. COUNTY <u>MONT Gomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross of Silver Spring</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District</u> b. COUNTY <u>OF Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1752 Lamont St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Lola</u> First Middle Last <u>C. Bennett</u>			4. DATE OF DEATH Month Day Year <u>3 20 1966</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9 12 1918</u>		9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Simon Peter Raymer</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Deloughter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Elizabeth Jane Bennett same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> <u>171X</u> DUE TO (b) <u>Squamous Carcinoma of Cervix</u> DUE TO (c) <u>12 mos.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February</u> , 19 <u>65</u> , to <u>March 20</u> , 19 <u>66</u> , that (I) <del>last</del> saw the deceased alive on <u>March 19</u> , 19 <u>66</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Harry N. Carlton</u>		22b. DATE SIGNED <u>3/20/66</u>		22c. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>	
22d. ADDRESS <u>909 Parkway Dr. Silver Spring, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			
23b. DATE THEREOF <u>3/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>The S.H. Hines Co.</u>		23d. LOCATION (City, town or county) (State) <u>Myersville, Md.</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>2901 14th St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Washington, D.C.</u>		DATE <u>MAR 23 1966</u>			

05300

05300



MAILED 23 JAN 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
03890 CERTIFICATE OF DEATH 03880												
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>6 days.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> d. STREET ADDRESS <b>16750 Batchelors Forrest Rd.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Henry</b>			First <b>Henry</b>		Middle <b>Lamar</b>		Last <b>Benson Sr.</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-29-1889</b>		9. AGE (In years last birthday) <b>76</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Henry Benson</b>					14. MOTHER'S MAIDEN NAME <b>Martha Booton</b>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>_____</b>					17. INFORMANT <b>HOSPITAL RECORD</b>					Address <b>_____</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain aneurysm hemorrhage</b> <b>4201</b> DUE TO (b) <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Coronary artery heart disease</b>										INTERNAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 days</b> <b>yr</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 <b>65</b> , to <b>3/24/65</b> , that (I) (we) last saw the deceased alive on <b>3/23/65</b> , and that death occurred at <b>1:40 AM</b> from the causes and on the date stated above.										22b. DATE SIGNED <b>3-24-66</b>		
22a. SIGNATURE <b>[Signature]</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Charles Ligon</b>	
22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			23b. DATE THEREOF <b>3-28-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>J. William Lee</b>			23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>				
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>					ADDRESS <b>Gaithersburg, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

Washington,  
14th and Mass. Ave. D. C.

J. William Lee

Creighton 3-28-66

Francis H. Barber, Esq. Baltimore, Md.

MAR 28 1866



1 (M)  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03891 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03881

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MARYLAND		c. LENGTH OF STAY IN 1b 1 Hr. 47 Min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Maryland	
		f. STREET ADDRESS 7206 Delafield Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Harold Sloop Berdine		4. DATE OF DEATH Month Day Year March 12 19 66	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 JULY 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - U.S. Coast Guard		9. AGE (In years last birthday) 64 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Binghamton, New York	
13. FATHER'S NAME Harry O. Berdine		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Mrs. Beulah E. Berdine (Wife)		18. ADDRESS 7206 Delafield Avenue, Chevy Chase, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Myocardial Infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis - (c) Cardio Vascular Disease -		INTERVAL BETWEEN ONSET AND DEATH Recent - hours - years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John B. Ball		22. DATE SIGNED 3/13/66	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-15-1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington Arlington Va.	
24. FUNERAL DIRECTOR Joseph Gawler & Sons		25a. REC'D BY REGISTRAR MAR 17 1966	
5130 Wisconsin Avenue N.W. Washington, D.C.		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03892

## CERTIFICATE OF DEATH

03882

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>ARLINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>			<b>83-3</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>2667 North Upshur St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Wells</b> Middle <b>Rood</b> Last <b>BILL, Jr.</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1966</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1916</b>	9. AGE (In years last birthday) <b>49 yrs.</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy Captain</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hartford, Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wells Rood Bill, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Lucia Sharp</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW2 &amp; Korea</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>Arlington, Va.</b> <b>Mrs. Marjorie W. Bill, 2667 N. Upshur St./</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis liver with hemorrhage</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Mar. 2</b> , 19 <b>66</b> , to <b>Mar. 6</b> , 19 <b>66</b> , that (2) (we) last saw the deceased alive on <b>Mar. 6</b> , 19 <b>66</b> , and that death occurred at <b>1150 M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>C. M. Herman</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Mar. 7, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. M. Herman M. D.</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/9/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>W. W. Chamber Funeral Home, 1400 Chapin St., N.W. Washington, D.C.</b>				25a. REC'D BY REGISTRAR <b>MAR 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

8220

12325

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03898

03883

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KENSINGTON</i> c. LENGTH OF STAY IN 15 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>SYLVAN MANOR HEALTH CENTER-2700 BARKER ST</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHEVY CHASE</i> d. STREET ADDRESS <i>2711 ROYCE ROAD</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <i>ESTHER</i> Middle <i>Blacker</i> Last <b>5. SEX</b> <i>FEMALE</i> <b>6. COLOR OR RACE</b> <i>WHITE</i> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>4. DATE OF DEATH</b> Month <i>3</i> Day <i>23</i> Year <i>1966</i> <b>8. DATE OF BIRTH</b> <i>12/1/1887</i> <b>9. AGE</b> (In years last birthday) <i>78</i> yrs. IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> IF UNDER 24 HRS.: Hours <i>0</i> Min. <i>0</i>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>AT HOME</i>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>RUSSIA</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>		<b>13. FATHER'S NAME</b> <i>MORRIS ?</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>RACHEL ?</i>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		<b>17. INFORMANT</b> <i>MRS. PEARL THROTT</i> Address <i>2711 ROYCE ROAD, CHEVY CHASE, MARYLAND</i>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause, or list for (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4341 Broncho-pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Due to Congestive Heart Failure</i> (c) <i>1 week</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture Femoral neck left femur - occurred 2/5/66</i>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <i>Patient fell out of bed at home</i>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <i>4</i> Hour <i>a.m.</i> <i>2/5</i> 19 <i>66</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i>Home</i>			
<b>20f. (City or town)</b> <i>Silver Spring</i> (County) <i>Montgomery</i> (State) <i>MD</i>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>2/5</i> , 19 <i>66</i> , to <i>3/23</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3/23</i> 19 <i>66</i> , and that death occurred at <i>6:30 P</i> M, from causes and on the date stated above.					
<b>22a. SIGNATURE</b> <i>MAX G. SHERER</i>		<b>22b. DATE SIGNED</b> <i>3/23/66</i>		<b>22c. PHYSICIAN'S NAME (Type)</b> <i>MAX G. SHERER MD</i>			
<b>22d. ADDRESS</b> <i>800 Pershing Dr. Silver Spring Md</i>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>REMOVAL</i>					
<b>23b. DATE THEREOF</b> <i>3/25/66</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>CEDAR PARK</i>		<b>23d. LOCATION (City or Town)</b> <i>PARAMUS, NEW JERSEY</i> (County) (State)			
<b>24. FUNERAL DIRECTOR</b> <i>SOL LEVINSON &amp; BROS. INC.</i>		<b>25a. REC'D BY REGISTRAR</b> <i>MAR 28 1966</i>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>J. Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

82251

RECORDS OF DEEDS

82251

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82251



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03894

CERTIFICATE OF DEATH

03884

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
c. LENGTH OF STAY IN 1b <b>1 day</b>		d. STREET ADDRESS <b>4019 Decatur Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>			
3. NAME OF DECEASED (Type or print) <b>Gary Arnold Blackwell</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 July 1928</b>
9. AGE (In years last birthday) <b>37 yrs.</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe store</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clyde Blackwell</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Varner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>251-30-0050</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda, Md. 20014</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right sided intracerebral hemorrhage</b> 2041 DUE TO (b) <b>Acute Myocardial infarction</b> DUE TO (c) <b>Chronic Myelogenous Leukemia</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b> <b>6 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 3, 1966</b> , to <b>March 3, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 3, 1966</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Alexander A. Levitan</b>		22b. DATE SIGNED <b>4 March 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Alexander A. Levitan, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		23b. DATE THEREOF <b>3-5-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Spartanburg, So. Carolina</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

03884

CHERRY CREEK, TEXAS

03884

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CHERRY CREEK, TEXAS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Items 18-21 Film G378 7 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 21 Film 379 8-11-66 ams

03895

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03885

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b .	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN HOSPT.</u>		d. STREET ADDRESS <u>6210 CRAITHIE LANE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA E. BLACKWELL</u>		4. DATE OF DEATH Month Day Year <u>MARCH 26 19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 25, 1911</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RICHARD FULGHUM</u>		14. MOTHER'S MAIDEN NAME <u>MARY REINHEIMER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROY BLACKWELL SAME AS # 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8780 Drug intoxication</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Overdose of several drugs</u> DUE TO (c) <u>2 hrs?</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deliberately took overdose of several drugs</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3/26 19 66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Glen Echo Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>March 26, 1966</u>	
ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>Belden R. Reap, M.D.</u>		22. DATE SIGNED <u>March 26, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/29/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FOUNTAIN PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>WINCHESTER INDIANA</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. WASHINGTON DC</u>		25a. REC'D BY REGISTRAR <u>MAR 31 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE	

6839

2832



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

Items 18-21 Film G3704-20-55 STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03896 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03886

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>803 Rosemere Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHESTER PAUL BLASZKIEWICZ</b>		4. DATE OF DEATH Month <b>3</b> Day <b>6</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/29/38</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tyle. Installer</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Blaszkiewicz, Stanley</b>		14. MOTHER'S MAIDEN NAME <b>Bryan, Agnes Jeanette</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		17. INFORMANT <b>Mother</b> <b>803 Rosemere St., S.S., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Partial transsection cervical spinal cord</b> <b>8/16 4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>at C6 and C7 with massive intracranial</b> (c) <b>hemorrhage.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Deceased was driver in head on collision with another motor vehicle</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased was driver in head on collision with another motor vehicle</b>	
20c. TIME OF INJURY Hour <b>7:05</b> p.m. Month, Day, Year <b>3/6 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Silver Spring Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Belden R. Reap, M. D.</b>		DATE SIGNED <b>March 7, 1966</b> Address (Street, city, town, or county) <b>Wheaton, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 9, 1966</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Burtonsville Union Cer.</b>		22d. LOCATION (City, town, or country) (State) <b>Burtonsville, Maryland</b>	
23. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		24a. REC'D BY REGISTRAR <b>MAR 10 1966</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

6238

1-3-1940



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

(M)

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03897  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03887

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Massachusetts</u> b. COUNTY <u>Florence</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jabara Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Florence</u> <u>58-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>195 Nonotuck STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robbin</u> Last <u>Robbin</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stationary Boilers</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>019-03-1164</u>	
17. INFORMANT <u>Mrs. Mary Ann Robbin</u>		Address <u>195 Nonotuck Florence, Mass.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5271 Congestive failure Rother left</u> DUE TO (b) <u>Pulmonary Hypertension &amp; Regurgitant Aorta</u> DUE TO (c) <u>Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>month</u> <u>week to</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/6/66</u> , 19 <u>66</u> , to <u>3/15/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/15/66</u> , 19 <u>66</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas H. Wolohon</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas H. Wolohon</u>		22d. ADDRESS <u>831 University Blvd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>March 19, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's XXXXXXXX Cem</u>		23d. LOCATION (City, town or county) (State) <u>Northampton, Mass.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 18 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03280

03280

MAY 12 1952

FOR STATE  
HEALTH DEPT.

03898

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03888

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hospital</u>		d. STREET ADDRESS <u>232 Dale Dr.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FRANK R. BOTELER</u>		4. DATE OF DEATH <u>3</u> Month <u>25</u> Day <u>1966</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-97</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bus operator-Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC Transit Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Boteler</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wignall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-10-8313</u>	
17. INFORMANT <u>Ruth L. Boteler-wife</u>		<u>232 Dale Drive Silver Spring, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute coronary insufficiency;</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary artery heart disease.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>March 25, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Washington, DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 28, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, DC</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> <u>8434 Georgia Avenue</u> <u>Silver Spring, Md</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03889

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DC 47-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>6372 31st PLACE, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>ROGER</u> Middle <u>T</u> Last <u>BOYDEN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10-1-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Boyden</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE L. Sherman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>WALTER W. AHREN'S, 717 Southern Bldg. Wash. D.C.</u>		Address <u>1425-H ST. N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac tamponade with rupture myocardium</u> DUE TO (b) <u>myocardial infarction</u> DUE TO (c) <u>coronary arteriosclerosis with occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u> <u>1 week</u> <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Ulcers, duodenal</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> , 19 <u>65</u> , to <u>MARCH 8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>MARCH 7</u> 19 <u>66</u> , and that death occurred at <u>6:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert L. Krichmar</u>		22b. DATE SIGNED <u>MARCH 8 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>		22d. ADDRESS <u>7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20012</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-10-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's, Sons.</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1966</u>	
ADDRESS <u>WASH. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in respective carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

022511

022511



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03890

FOR STATE HEALTH DEPT.

03900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>2 hrs - 20 min</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San't Hospital</u>		d. STREET ADDRESS <u>727 Univ Blvd. E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Vincent Bright</u> First Middle Last		4. DATE OF DEATH <u>3</u> <u>8</u> <u>1966</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-10</u> 9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>music Booker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Jimmie Meekers Music</u>	11. BIRTHPLACE (State or foreign country) <u>Norfolk, Va.</u>
13. FATHER'S NAME <u>Bright, Thibear</u>		14. MOTHER'S MAIDEN NAME <u>Bailey, Dorothy Mae</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>578-09-5326</u>	
17. INFORMANT <u>Wife</u> <u>Dorothea Bright</u> <u>727 University Blvd.</u> <u>East XXXXX S.S. Md</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>March 9, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 11, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>MAR 14 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00280

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03901

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03891

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ma.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Dickerson.</u>				c. LENGTH OF STAY in 1b -- <u>35 yrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Dickerson.</u>				15-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. Dickerson.</u>				d. STREET ADDRESS <u>R.F.D. Dickerson.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>John Michael Burke Sr.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1966</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/10/1888</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>			
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Peter Burke</u>				14. MOTHER'S MAIDEN NAME <u>P.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes.</u> <u>N. V. I. 25A 200-28-5975</u>				16. SOCIAL SECURITY NO. <u>200-28-5975</u>			
17. INFORMANT <u>Son</u> Address <u>John M. Burke - 214 Highland Ave. Rockville, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Chest.</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>976X</u> DUE TO (c) <u>976X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self with shotgun</u>			
20c. TIME OF INJURY Month, Day, Year <u>12:30 p.m. 3/2 1966</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Dickerson</u> (County) <u>Mont.</u> (State) <u>Ma.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.				22. DATE SIGNED <u>3/2/66</u>			
EXAMINER'S NAME (Type) <u>John B. Ball</u>				Address (Street, city, town, or county) <u>Dickerson - Mont. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington North Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR <u>William B. Hillon, Barnesville, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>MAR 7 1966</u>							

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LIBRARY OF THE  
MUSEUM OF NATURAL HISTORY  
NEW YORK



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## MEDICAL CERTIFICATION

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Montgomery

Rock Spring

Rock Creek

Rock

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W

Chamber

C

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2500 Lake View St

Key West

Montgomery

Montgomery

10003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bethesda-Silver Spring Nursing Home</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>4117 38th St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>Pauline</b> First Middle Last <b>F. Campbell</b>			<b>4. DATE OF DEATH</b> <b>March 10 1966</b> Month Day Year		<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>12-4-1866</b> <b>9. AGE</b> (In years last birthday) <b>99</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> - - -			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D. C.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			<b>13. FATHER'S NAME</b> <b>Florian Friederich</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Magdalene Lederer</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) - - -			<b>16. SOCIAL SECURITY NO.</b> - - -		<b>17. INFORMANT</b> <b>Miss Florence Campbell- See Item #2.</b> Address				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Similarity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myocarditis with congestive failure</b> DUE TO (c) <b>Hypertension Severe</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>8 mo.</b> <b>8 mo.</b> <b>50 yrs</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Mitral and Aortic Stenosis 50 yrs +</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from July 19, 1965, to March 10, 1966, that (I) (we) last saw the deceased alive on March 9, 1966, and that death occurred at 9:15 M, from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>J. D. Damian</b> <span style="float: right;">M.D.</span> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr Jules D. Damian</b>						<b>22b. DATE SIGNED</b> <b>March 10 1966</b> <b>22d. ADDRESS</b> <b>2741 34th St. N.W.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>3-12-1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Congressional Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Washington, D.C.</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Joseph Gawler's Sons, Inc.</b> <b>6130 Wisc. Ave. N.W. Washington, D.C.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>MAR 14 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>J Charles Judge</b>	

3300

DEPARTMENT OF DEATH

1934

Washington

Dist. of Col.

Washington

Washington - River 3-10-1934

38th St. N.W.

Washington

Cambridge

March 10

Washington 3-10-1934

Washington, D.C.

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Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03805

03895

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Puerto Rico</u> b. CDUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Loiza Aldea</u> 92-3			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>Barrio Mediania Alta</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Segundo Osorio Carrasquillo</u>				4. DATE OF DEATH Month Day Year <u>March 31 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 May 1932</u>	
9. AGE (in years last birthday) <u>33</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Not employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Puerto Rico</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Gabriel Osorio</u>			
14. MOTHER'S MAIDEN NAME <u>Bernabela Carrasquillo</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1952-1954</u>			
16. SOCIAL SECURITY NO. <u>580-30-6567</u>				17. INFORMANT <u>The Medical Records, National Institutes of Health, Bethesda, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage, left temporal lobe</u> <u>2043</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myelogenous leukemia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fibrinous pericarditis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>  <u>16 days</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>March 29</u> , 1966, to <u>March 31</u> , 1966, that <u>XX</u> (we) last saw the deceased alive on <u>March 31</u> , 1966, and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Herman A. Godwin, Jr.</u>				22b. DATE SIGNED <u>April 7, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Herman A. Godwin, Jr., M.D.</u>	
22d. ADDRESS <u>Institutes of Health, Bethesda, Md.</u>				22e. REC'D BY REGISTRAR <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR. 11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SAN JUAN, PUERTO RICO</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>M.W. Hysong Co. Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Per: Thomas W. Hysong</u>				25c. REGISTRAR'S SIGNATURE <u>Washington, D.C.</u>			

05285

05285

Acute myelogenous leukemia  
In bone marrow, left temporal lobe  
In bone marrow, left temporal lobe

Pathologic description

March 21, 1966

March 21, 1966

March 21, 1966

12:42

04

Thomas A. Brown, Jr., M.D.

12:42

March 21, 1966



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File (pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

03906

STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03896

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>13 YRS.</u>		d. STREET ADDRESS <u>2502 Henderson Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2502 Henderson Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>LUCILLE</u> Last <u>CHILDERS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 8, 1891</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN CHARLES HEIDE</u>		14. MOTHER'S MAIDEN NAME <u>MARY FRANCES KIRBY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-07-3361</u>	
17. INFORMANT <u>MARY JANE NEIL (DAUGHTER)</u>		17. ADDRESS <u>14720 JANICE DR., ROCKVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4201 DUE TO (b) <u>Essential Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u>		22. DATE SIGNED <u>March 1, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		22. ADDRESS (Street, city, town, or county) <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/4/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>JAS. T. RYAN, INC.</u>		ADDRESS <u>317 PARK SE DC</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>MAR 4 1966</u>			

2026

*[Faint handwritten text at the bottom of the page]*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03907

03897

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7204 Conn. Ave.</u>		d. STREET ADDRESS <u>7204 Conn. Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Agale Elizabeth Christie</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>20 Jan. 1915</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk - typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christie.</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Henderson.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>060-20-4617</u>	
17. INFORMANT <u>Mrs. Malcolm P. Thompson</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis -</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>4/2/66</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>  </u>		23a. REC'D BY REGISTRAR <u>APR 6 1966</u>	
23b. DATE THEREOF <u>April 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kensco Cemetery</u>	
23d. LOCATION (City or town) (County) (State) <u>Val Halla N.Y.</u>		23e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23f. FUNERAL DIRECTOR <u>  </u>		23g. ADDRESS <u>254 Carroll St NW</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03898

## CERTIFICATE OF DEATH

03898

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b> COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>				c. LENGTH OF STAY IN 1b <b>165 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>2224 40th Street N. W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Harvey Jacob Christman Jr.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 July 1916</b>	9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lehigh, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harvey Jacob Christman, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Martha Jane Snyder</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1943 - 1966</b>		16. SOCIAL SECURITY NO. <b>202 10 8541</b>		17. INFORMANT <b>Mrs. Frances Christman Washington, D. C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiectasis with associated diffused</b> <b>526X</b> DUE TO <b>interstitial pulmonary fibrosis and</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pneumonia</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4 October, 1965</b> , to <b>18 March, 1966</b> , that (I) (we) last saw the deceased alive on <b>18 March 19 66</b> , and that death occurred at <b>9:22 M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>J. E. Zimmerman</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>19 March 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. E. Zimmerman, LT MC USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-22-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b>		5130 Wisconsin Avenue <b>Washington, D. C.</b>		25. READ BY REGISTRAR <b>MAR 24 1966</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> <span style="float: right;">b. COUNTY <u>✓</u></span>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>						c. LENGTH OF STAY IN 1b <u>2 mos. 24 days 3 1/2 hrs.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>						e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Alpha</u> Middle <u>Irene</u> Last <u>Clark</u>						<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>21</u> Year <u>1966</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>August 8, 1892</u>		<b>9. AGE</b> (In years last birthday) <u>73</u> yrs. <div>             IF UNDER 1 YEAR: Months <u>4</u> Days <u>7</u> </div> IF UNDER 24 HRS.: Hours <u>3</u> Min. <u>3</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Teacher - Retired</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Teacher - Retired</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>California</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Harry Kulison</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Wilamena Butenop</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>No</u>		<b>17. INFORMANT</b> Address <u>Hospital Records</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>2865</u> DUE TO <u>Pulmonary Embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition</u> (c) <u>Fatty infiltration of liver</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 months</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Fatty infiltration of liver</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from <u>Dec 24, 1965</u>, to <u>March 21, 1966</u>, that (II) (we) last saw the deceased alive on <u>March 20, 1966</u>, and that death occurred at <u>3:30 AM</u>, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Lytle W. Williams</u>						<b>22b. DATE SIGNED</b> <u>March 21, 1966</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Lytle W. Williams</u>						<b>22d. ADDRESS</b> <u>831 University Blvd E Silver Spring, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>			<b>23b. DATE THEREOF</b> <u>3-22-66</u>			<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lee's Crematory</u>			<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington, D.C.</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Lee Funeral Home</u>						<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Washington, D.C. MAR 24 1966</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
3. NAME OF DECEASED (Type or print) <b>M. GERTRUDE CLARKSON</b>		4. DATE OF DEATH Month <b>March</b>		Day <b>2,</b>		Year <b>1966</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 11, 1897</b>		9. AGE (In years last birthday) <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor - Gov't</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Charles Hildebrand</b>				14. MOTHER'S MAIDEN NAME <b>Annie Summers</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Husband</b>		Address <b>Same as Item 2.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio Sclerosis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>220</b>		20f. (City or town) <b>220</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 2, 1965</b> to <b>Mar 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 9, 1965</b> , and that death occurred at <b>2:45</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>AIS BOWIE</b>				22b. DATE SIGNED <b>3-2-66</b>		22c. PHYSICIAN'S NAME (Type) <b>AIS BOWIE</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/7/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey Bethesda, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

Dr Ball coroner notified & approved

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30-2-1

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

03911

03901

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. LENGTH OF STAY IN 1b <u>years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3535 Chevy Chase Lake Dr.</u>				d. STREET ADDRESS <u>3535 Chevy Chase Lake Dr.</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth R. Cole</u>				4. DATE OF DEATH <u>March 14 1966</u>			
5. SEX <u>Fe.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1902</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Warren R. Roberts</u>			
14. MOTHER'S MAIDEN NAME <u>Lucy Stewart</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>340-20-5956</u>				17. INFORMANT <u>Kenneth S. Cole</u> Address <u>Item 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis with Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis of Coronary Arteries</u> DUE TO (c) <u>Years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <u>3/17/66</u>				ACTUAL SIGNATURE <u>John G. Ball</u> M.D. EXAMINER'S NAME (Type) <u>John G. Ball</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3-19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> <u>1351 Rockville Pike, Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 23 1966</u>		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03912					03902				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Montgomery</u>					a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				
c. LENGTH OF STAY IN 1b <u>12 days</u>					d. STREET ADDRESS <u>8802 Bradford Rd.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Fern Marie Colton</u>					4. DATE OF DEATH <u>3/21/66</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>2/16/05</u>				
9. AGE (In years last birthday) <u>61 yrs.</u>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary in U.S. Accounting Govt.</u>				
11. BIRTH PLACE (County & State, or foreign country) <u>Wisconsin</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>John A. Anderson</u>					14. MOTHER'S MAIDEN NAME <u>Clara M. Johnson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>					16. SOCIAL SECURITY NO. <u>493-20-8571</u>				
17. INFORMANT <u>Homer C. Colton</u>					Address <u>8802 Bradford Road Silver Spring, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial <del>insufficiency</del> Insufficiency</u> 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>Col methylosis</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1 Jan</u> , 19 <u>66</u> , to <u>21 March</u> , 1966, that (I) (we) last saw the deceased alive on <u>21 March</u> 19 <u>66</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Thomas P. Forgarty</u>					22b. DATE SIGNED <u>Mar. 21 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Thomas P. Forgarty</u>					22d. ADDRESS <u>1011 University Blvd., Silver Spring, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>March 24, 1966</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Hiram Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Creve Coeur Co., Missouri</u>				
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					25c. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				

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13-05-69

25/12.2015

Source: U.S. Census Bureau, *Current Population Reports*, 1990.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03913

03903

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>			
c. LENGTH OF STAY IN 1b <u>3 days, 10 hr. 10 min</u>				d. STREET ADDRESS <u>8402 20th Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Danny</u> Last <u>Connor</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 5, 1947</u>	
9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.A.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DC</u>	
13. FATHER'S NAME <u>John Connor</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mola</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> <u>1934</u> DUE TO (b) <u>Metastatic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>atypical neuroblastoma</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>18 months</u> <u>22 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>64</u> , to <u>Mar 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Mar 27</u> 19 <u>66</u> , and that death occurred at <u>3:50</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Arthur S. Bresler</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR S. BRESLER</u>				22d. ADDRESS <u>10851 LOCKWOOD DRIVE, SILVER SPRING</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/30/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Valley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 1 1966</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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03039

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03914 CERTIFICATE OF DEATH					03904					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>30 DAYS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 15-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross</u>					d. STREET ADDRESS <u>8102 PARK CREST DR.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>PETER A. CONNOR</u>					4. DATE OF DEATH <u>MARCH 26</u> 19 <u>66</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-6-1886</u> 79 yrs.		9. AGE (in years last birthday) IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Min. <u>15</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Asst. to Dir. transp. Div. G. A. O.</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MASSACHUSETTS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Connor</u>					14. MOTHER'S MAIDEN NAME <u>Agnes C. Connor</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>					16. SOCIAL SECURITY NO. <u>220-44-5806</u>		17. INFORMANT <u>Agnes C. Connor</u> Address <u>8102 Park Crest Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Acedasis</u> <u>5271</u> DUE TO <u>Chronic pulmonary emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pulmonary emphysema</u> DUE TO (c) <u>Chronic pulmonary emphysema</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>65</u> , to <u>3/26/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/26/66</u> 19 <u>66</u> , and that death occurred at <u>9 PM</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Jay R. Shapiro MD</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-27-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAY R. SHAPIRO MD</u>					22d. ADDRESS <u>8218 LANSLOW AVE BETHESDA</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>29 March 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		23d. LOCATION (City, town or county) (State) <u>Forest Glen, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> Address <u>8434 Georgia Avenue Silver Spring, Maryland</u>					25a. REC'D BY REGISTRAR <u>MAR 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03915 03905											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			c. LENGTH OF STAY IN 1b <u>23 hrs. 45 min.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> 16-2						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH STATE Hospital</u>					d. STREET ADDRESS <u>4803 Erie Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mimi</u> First <u>MIMI</u> Middle <u>(CORNELL)</u>					4. DATE OF DEATH <u>March 12 1966</u>		Month <u>March</u> Day <u>12</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/7/66</u>		9. AGE (in years last birthday) <u>1 mo</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Owen B. Cornell</u>					14. MOTHER'S MAIDEN NAME <u>Ruth M. Shinkard</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>chart</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyloric stenosis accompanied by electrolyte</u> <u>7560</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>imbalance, malnutrition, and dehydration.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>March 12, 1966</u>				
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (street, city, town, or county) <u>Colmar Manor Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>March 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincol</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor Md</u>				
24. FUNERAL DIRECTOR <u>F. Busche and Hyattsville Md</u>					ADDRESS		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
DATE <u>MAR 21 1966</u>											

1908

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like 'plant' and 'industrial' are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03916

03906

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium</b>			d. STREET ADDRESS <b>8004 - 14th Avenue</b>		
3. NAME OF DECEASED (Type or print) <b>CHARLES ANDERSON COTTRELL, SR.</b>			4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 66</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1896</b>	9. AGE (in years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>24</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Richmond, Virginia</b>	
13. FATHER'S NAME <b>Julian S. Cottrell</b>			14. MOTHER'S MAIDEN NAME <b>Eva Anderson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>WASHINGTON SMITH NEWBORN RECORDS</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic pyelonephritic</b> <b>6000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 w. 4 d.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BENIGN PROSTATIC HYPERTROPHY</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/27/66</b> , 19 <b>66</b> , to <b>3/2/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/2/66</b> , 19 <b>66</b> , and that death occurred at <b>2:28</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Richard H. Pollen</b>			22b. DATE SIGNED <b>3/2/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>RICHARD H. POLLEN</b>			22d. ADDRESS <b>10511 Summit Ave., Kensington, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/4/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Prince Geo. Co., Md.</b>		
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Bethesda, Md.</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>		

113005

03310

804 - 10th Avenue

CHAS. E. KELLEY, JR.

Sept. 6, 1946

Chicago, Ill.

Dear Sir:

Enclosed

Chicago, Ill.

Very truly yours,

*James H. Kelley*

James H. Kelley, Jr.

Chicago, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> <span style="float: right;">b. COUNTY <u>✓</u></span>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> <span style="float: right;">83-3</span>				d. STREET ADDRESS <u>4271 S. 35<sup>th</sup> St. Apt B-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charlotte Tucker Creel</u>						<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>26</u> Year <u>1966</u>							
<b>5. SEX</b> <u>Fe</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12-1-06</u>		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Computer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>  </u>			
<b>13. FATHER'S NAME</b> <u>Randolph T.</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Stickley</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>224-60-0390</u>		<b>17. INFORMANT</b> <u>Hospital Records</u> <span style="float: right;">Address <u>  </u></span>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Paralytic ileus</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of cervix</u> DUE TO (c) <u>Metastasis to liver</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days</u> ? ?			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Exploratory laparotomy on 3-17-66</u>													
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Mar. 15, 1966</u> , <b>to</b> <u>Mar. 26, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Mar. 26, 1966</u> , <b>and that death occurred at</b> <u>3:20 PM</u> , <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Paul V. Starr</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Mar. 26-1966</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>PAUL V. STARR</u>						<b>22d. ADDRESS</b> <u>7802 Glenide Dr., Takoma Park, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/29/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Annandale Methodist Church Cemetery, Annandale, Va.</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>  </u>					
<b>24. FUNERAL DIRECTOR</b> <u>Deborah Jones</u> <span style="float: right;">ADDRESS <u>520 S. Washington St.</u></span>						<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judy</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judy</u>					
<b>25c. DATE</b> <u>MAR 30 1966</u>						<b>25d. SIGNATURE</b> <u>Charles Judy</u>							

MEDICAL CERTIFICATION

10000

10000

Amendable to the Constitution of the United States



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

103908

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY IN <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURSING HOME</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>1000 CRAWFORD DR.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>MARY C. CRONISE</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH 27 1966</u>				
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7/4/1884</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>23</u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			<b>13. FATHER'S NAME</b> <u>William Groff</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Lilly Trundle</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
<b>16. SOCIAL SECURITY NO.</b> <u>yes-unknown</u>			<b>17. INFORMANT</b> Address <u>hospital records</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>diabetes mellitus</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>21 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease</u>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1960</u> , <b>to</b> <u>3-27, 1966</u> , <b>that (I) (we) lost</b> <b>saw the deceased alive on</b> <u>3-25</u> <b>19</b> <u>66</u> , <b>and that death occurred at</b> <u>2 p.m.</u> <b>from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>DL Bucy</u>			<b>22b. DATE SIGNED</b> <u>3-27-66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>DL Bucy</u>		
<b>22d. ADDRESS</b> <u>809 Vero Mill Rd. Rockville</u>			<b>23a. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>				
<b>23b. DATE THEREOF</b> <u>3/30/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rockville Cemetery</u>		<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Rockville, Maryland</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Robert A. Pumphrey Bethesda, Md.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>MAR 30 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10308

RECEIVED

10308

10308

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03919

03909

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>4m?</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route I Walkers Farm.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna Olivia Daniels</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1966</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1924</b>
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months <b>41</b> Days <b>41</b> Hours <b>41</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Florence Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Corrine Forman (sister)</b>		Address <b>Item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Fatty Metamorphosis of Liver</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John L. Ball</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <b>3/22/66</b>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>BURIAL</b>	<b>3/28/66</b>	<b>Ash Memorial</b>	<b>Sandy Spring Montg. Md.</b>
24. FUNERAL DIRECTOR <b>Robert L. Anwarden</b>		25a. REC'D BY REGISTRAR <b>Rockville, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 29 1966</b>	

00050

0135

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03920

CERTIFICATE OF DEATH

03910

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN b <b>33 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>Route 1, Box 135</b>	
3. NAME OF DECEASED (Type or print) First <b>Nicki</b> Middle <b>Arlan</b> Last <b>DANIELS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1950</b>
9. AGE (In years last birthday) <b>15</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>8</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Moorehead City, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anthony N. Daniels</b>		14. MOTHER'S MAIDEN NAME <b>Adolya Guthrie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>SGT Anthony N. Daniels</b>		Address <b>Oceanside, Cal.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Endocarditis</b> <b>4301</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>Feb. 12</b> , 19 <b>66</b> , to <b>Mar. 17</b> , 19 <b>66</b> , that <b>(H)</b> (we) last saw the deceased alive on <b>Mar. 17</b> , 19 <b>66</b> , and that death occurred at <b>640 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>R. C. Johnson</b>		22b. DATE SIGNED <b>Mar. 18, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. C. Johnson, M. D.</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal/Burial</b>	23b. DATE THEREOF <b>3/21/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bay View</b>	23d. LOCATION (City or Town) (County) (State) <b>Morehead City, N. C.</b>
24. FUNERAL DIRECTOR <b>R. A. Pumphrey Funeral Home</b> <b>7557 Wisconsin Ave., Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 22 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

01259

RECEIVED

03230

Monterey City

1951

Student

1951

Inventory

1951/1952

1951/1952



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03921

## CERTIFICATE OF DEATH

03911

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
c. LENGTH OF STAY IN TB <u>4 days</u>		d. STREET ADDRESS <u>10225 KENSINGTON PKWY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>H</u> Last <u>DASSORI</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-1878</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR <u>1</u> Months <u>8</u> Days <u>8</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICAL ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FREDERICK DASSORI</u>		14. MOTHER'S MAIDEN NAME <u>ELISE DASSORI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>FREDERIC D. DASSORI</u>		Address <u>STUART FLORIDA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> DUE TO (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROTIC HEART DIS. NOT YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-1/2 HRS</u> <u>3+ YRS</u> <u>DIS. NOT YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PNEUMONIA, TUBERCULOSIS, UREMIA, POSS. G.I. MALIG</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u>7:00</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY, 1963</u> , to <u>3/2, 1966</u> , that (I) (we) last saw the deceased alive on <u>3/1, 1966</u> , and that death occurred at <u>12:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles Savanese, M.D.</u>		22b. DATE SIGNED <u>3/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES SAVANESE, M.D.</u>		22d. ADDRESS <u>11125 ROCKVILLE PIKE ROCKVILLE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-trans.</u>	23b. DATE THEREOF <u>3/4/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, N.Y.</u>
24. FUNERAL DIRECTOR <u>Robert C. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11210

STANDARD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03922

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03912

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>1 hour 55 min</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b> d. STREET ADDRESS <b>13-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Davis</b>		4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>19 66</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 16, 1966</b>	
9. AGE (In years last birthday) <b>1</b> yrs. <b>1</b> month <b>55</b> days		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>55</b> Hours <b>1</b> Min <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>New Born</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Davis</b>		14. MOTHER'S MAIDEN NAME <b>Vallie Summerfield</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Medical Records, Olney Md.</b>	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1) prematurity 2) Hydranmies 3) breech</b> <b>7615</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>presentation post. asfixia</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>7<sup>30</sup></b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>J. S. C. LAIN MD</b> M.D.		22b. DATE SIGNED <b>ATTESTING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></b>	
22c. PHYSICIAN'S NAME (Type) <b>J. S. C. LAIN MD</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/18/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Howard Co. Md.</b>	
24. FUNERAL DIRECTOR <b>C.M. Waltz Box 241 Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03928					03913									
Item 15, Film G376 4/27/66														
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>172 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Pensacola</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48-3</b> d. STREET ADDRESS <b>5972 Pursley Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>Max Howard Davis</b>					4. DATE OF DEATH Month Day Year <b>March 4 1966</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>19 March 1935</b>		9. AGE (In years last birthday) <b>30 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lieutenant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>								
13. FATHER'S NAME <b>Max Davis</b>					14. MOTHER'S MAIDEN NAME <b>Lola R. Robinson</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1956-present 1965</b>					16. SOCIAL SECURITY NO. <b>234-52-9033</b>					17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Md. 20014</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Septicemia</b> <b>2041</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Chronic Myelogenous Leukemia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>16 hours</b> <b>3 years</b>														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)														
21. I certify that <b>MD</b> (this hospital) attended the deceased from <b>September 13, 1965</b> , to <b>March 4, 1966</b> , that <b>MD</b> (we) last saw the deceased alive on <b>March 4, 1966</b> , and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Wesley M. Vietzke</b>					22b. DATE SIGNED <b>4 March 1966</b>									
22c. PHYSICIAN'S NAME (Type) <b>Wesley M. Vietzke, M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 3-5-66</b>		23b. DATE THEREOF <b>3-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Barancas Natl Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Pensacola, Florida</b>								
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>					25a. REC'D BY REGISTRAR <b>MAR 8 1966</b>					25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>				

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
 HEALTH DEPT.

03924

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03914

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>22 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>OLIVE</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>19 66</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-17-89</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS SAXTON</u>				14. MOTHER'S MAIDEN NAME <u>LOUISA GELBERT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>PT. RECORD</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive intrapontine and intraventricular hemorrhage.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hemorrhage.</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Leap</u> M.D.				22. DATE SIGNED <u>March 3, 1966</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. LEAP M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Adelphi P. O. Co. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Adelphi P. O. Co. Md</u>	
24. FUNERAL DIRECTOR <u>G. W. Watters, 254 Carroll St. N.W. DC</u>				25a. REC'D BY REGISTRAR <u>1 MAR 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03915

03925

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>W.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4225-7th St. S.E.</u>			
3. NAME OF DECEASED (Type or print) <u>Steward Griffith Davis</u>				4. DATE OF DEATH <u>March 17</u> 19 <u>66</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/28/95</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>draftsman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Edward Davis</u>				14. MOTHER'S MAIDEN NAME <u>WINIFRED Steward</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>			16. SOCIAL SECURITY NO. <u>46743-0029</u>		17. INFORMANT <u>Lee Davis / same as above</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insofficiency. Acute -</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease -</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Bell</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <u>3/17/66</u>	
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
			Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Burial</u>		<u>3/22/66</u>		<u>Arlington NAT</u>		<u>Arlington Va</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>1400 Chapin NW DC</u>				DATE <u>MAR 23 1966</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT.

03926

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03916

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>30-4</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Asbury Methodist Home</u>				d. STREET ADDRESS <u>Charles + 24<sup>th</sup> St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Enma Naomi Dawson</u>				4. DATE OF DEATH Month Day Year <u>March 29 19 66</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1878</u>		9. AGE (In years last birthday) yrs. <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George M. Morgan</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Delcher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Asbury Methodist Home</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>9047</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture of Rt. Femur</u> DUE TO (c) <u>Arterio Sclerosis - generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>45 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at Nursing Home causing Fract. of Rt. Femur</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:30</u> <u>2/12</u> <u>19 66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Gaithersburg Mont Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>John L. Ball</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>3/29/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 1, 19 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Wilmington, Delaware</u>	
24. FUNERAL DIRECTOR ADDRESS <u>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</u>				25a. REC'D BY REGISTRAR DATE <u>Apr 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03927

03917

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>3 wks.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda-Silver Spring Nursing Home</u>		d. STREET ADDRESS <u>3722 Manor Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>L.</u> Last <u>DEBINDER</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-12</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TOTEMAC ELEC. POWER CO. WASHINGTON, DC.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>C.B. DOYLE</u>		14. MOTHER'S MAIDEN NAME <u>MARY REGINA SHECKELS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>Mrs. SHARON LEE Young</u>		Address <u>5616-23 4<sup>th</sup> PARKWAY, HILLOREST HTS. MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of larynx with</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized metastasis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 16, 1963</u> to <u>March 8, 1966</u> that (I) (we) last saw the deceased alive on <u>March 7, 1966</u> , and that death occurred at <u>2 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert N. Coale</u>		22b. DATE SIGNED <u>March 8, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		22d. ADDRESS <u>4429 Bradley Lane Cherry Chase Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-11-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03928

03918

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Colver</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Box 96</b> d. STREET ADDRESS <b>Box 96</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>(None)</b> Last <b>DeGretto</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 February 1916</b>
9. AGE (In years last birthday) <b>50 yrs.</b>		10. IF UNDER 1 YEAR Months <b>50</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Lanesky</b>		14. MOTHER'S MAIDEN NAME <b>Tressa Yowersky</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		18. ADDRESS <b>The Clinical Center, Bethesda, Md. 20014</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nasal Pharyngeal Bleeding</b> <b>201X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hodgkin's Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>1 1/2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>OK</del> (this hospital) attended the deceased from <b>February 25, 1966</b> to <b>March 7, 1966</b> , that <del>XX</del> (we) last saw the deceased alive on <b>March 7, 1966</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert S. Brown</b>		22b. DATE SIGNED <b>7 March 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert S. Brown, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 3/8/66</b>	23b. DATE THEREOF <b>3/8/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Name Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Ebensburg, Penna.</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 10 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03929					03919				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY				
Montgomery MARYLAND					Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Takoma Park D.C.					Hyattsville 16-2				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
Wash San Hospital					2011 Hannon St.				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
Christine (Hresula) Demas					3 8 1966				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		3-18-1884		81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
Nurse					Greece				
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Greece					Greece				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Nicholas Kontos					Not Known				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.				
no					17. INFORMANT				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
332X Cerebral Thrombosis					INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					2 weeks				
DUE TO (b) Generalized arteriosclerosis					10 yrs +				
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED				
Hour a.m. p.m. 19					While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Mon, 1965, to Mon, 1966, that (I) (we) last saw the deceased alive on Jan. 6 1966, and that death occurred at 11:00 A.M. from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
Ira M. Grassgreen M.D.					3-8-66				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
IRVIN M. GRASSGREEN M.D.					3101 ARUNDEL RD, MT. RAINIER M.D.				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF				
Burial					3/10/66				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town or county) (State)				
Cedar Hill Cemetery					Suitland, Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR				
The S.H. Hines Co., Washington, D.C.					MAR 9 1966				
					25b. REGISTRAR'S SIGNATURE				
					Charles Judge				

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film G376 5/2/66 mh

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03930

03920

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>11 yr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9404 Balfour Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha Catherine De Priest</u>		4. DATE OF DEATH <u>March 18 1966</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7, 1900</u>
9. AGE (In years lost birth day) <u>66 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Gov.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Washington Tyler</u>		14. MOTHER'S MAIDEN NAME <u>Rose Norton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Husband</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Radio Vascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u>		22. DATE SIGNED <u>3/19/66</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		23a. BURIAL, CREMATION, RITUAL <u>BURIAL</u>	
23b. DATE THEREOF <u>3/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK</u>	
23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>		24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. 8655 GA. AVE. SILVER SPRING</u>	
25a. REC'D BY REGISTRAR <u>MAR 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

03931

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03921

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13003 Atlantic Ave.</u>		d. STREET ADDRESS <u>13003 Atlantic Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>Adam</u> Last <u>DeWitt</u>		4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W-</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Feb. 1917</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herbert E. DeWitt</u>		14. MOTHER'S MAIDEN NAME <u>Vinia Bogg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>227-18-5521</u>	
17. INFORMANT <u>Katherine M. DeWitt--same item # 2-wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Head -</u> <u>976x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Shot - Self-infected Shot Gun. 12 gauge -</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3:45</u> p.m. <u>3/7</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rockville - Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <u>3/7/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/9/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		ADDRESS <u>1331 Rock. Pike, Rockville, Md.</u>	
25a. REC'D BY REGISTRAR <u>MAR 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03932					03922				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Montgomery			a. STATE		Maryland		
		MARYLAND			b. COUNTY		Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Kensington			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda		
		8 MOS. 14 DAYS					15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
Carroll Hall Sanitarium					4510 Maple Avenue				
e. IS RESIDENCE ON A FARM?					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED					4. DATE OF DEATH				
First Middle Last					Month Day Year				
PAULINE A. DIETERICH					March 24, 1966				
(Type or print)									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct. 25, 1882		83 yrs.	
								Months Days Hours Min.	
								4 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
Housewife					-----				
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Germany					Germany				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
George Schneider					Marie Zimmerman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.				
No					None				
17. INFORMANT					Address				
Daughter					4716 Bradley Blvd.				
Mrs. Hedwig Anding					Cheve Chase, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Terminal Bronchopneumonia									
334X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Cerebral Atherosclerosis, due to									
DUE TO									
(c) Arteriosclerosis, general									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
Diabetes Mellitus, unid									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year									
Hour a.m. p.m. 19									
20d. INJURY OCCURRED									
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from July 21, 1958, to March 24, 1966, that (I) (we) last saw the deceased alive on MAR. 24, 1966, and that death occurred at 1:53 P.M. from the causes and on the date stated above.									
22a. SIGNATURE									
Robert G. Angle									
22b. DATE SIGNED									
MAR. 24, 1966									
22c. PHYSICIAN'S NAME (Type)									
ROBERT G. ANGLE									
22d. ADDRESS									
5009 Del Ray Ave., Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
Burial									
23b. DATE THEREOF									
3-26-66									
23c. NAME OF CEMETERY OR CREMATORY									
Rockville Cemetery									
23d. LOCATION (City, town or county) (State)									
Rockville, Maryland									
24. FUNERAL DIRECTOR									
ADDRESS									
ROBERT A. PUMPHREY Bethesda, Maryland									
25a. REC'D BY REGISTRAR									
MAR 28 1966									
25b. REGISTRAR'S SIGNATURE									
Charles Judge									

3826



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03933 CERTIFICATE OF DEATH 03923									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Virginia</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>46 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> 83-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>					d. STREET ADDRESS <b>4226 Vermont Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ruth Ann Dixon</b>			First Middle Last		4. DATE OF DEATH <b>March 28 1966</b>		Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 August 1937</b>		9. AGE (In years last birthday) <b>28</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>S. Howard Sheppard</b>					14. MOTHER'S MAIDEN NAME <b>Ruth E. Hutchinson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>225-46-3924</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalitis</b> 201x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hodgkin's Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>1 Month</b> <b>4 1/2 Years</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <b>10 February 1966</b> , to <b>28 March 1966</b> , that (we) last saw the deceased alive on <b>28 March 1966</b> , and that death occurred at <b>8:55 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Wesley M. Vietzke, M.D.</b>					22b. DATE SIGNED <b>28 March 1966</b>			22c. PHYSICIAN'S NAME (Type) <b>Wesley M. Vietzke, MD.</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					22e. REC'D BY REGISTRAR <b>APR 1 1966</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>April 1, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR <b>Wm. Demaine &amp; Son Funeral Home, Alexandria, Virginia</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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Virginia

Montgomery

Alexandria

Ad Day

Bethesda

The Clinical Center, Bethesda 1A, Maryland 20892

Ann Dixon March 10 1977

Female White 2 August 1977

Secretariat Virginia USA

Dr. Howard Shepard

Dr. S. Hutchinson

The Clinical Center, Bethesda 1A, Maryland

1 female

Ad Day

Hodgkin's Disease

10 February 1977

8:55

10 Feb 77

1 20 March 1977

The Clinical Center, Bethesda 1A, Md.

Dr. S. Hutchinson

1 20 March 1977

The Clinical Center, Bethesda 1A, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross 1500-Forest Glen Rd</b>				d. STREET ADDRESS <b>11014 Gluck Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Myra E. Donnelly</b>				4. DATE OF DEATH <b>3 - 20 - 1966</b>				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-16-20</b>		9. AGE (In years last birthday) <b>45</b> rs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>			
13. FATHER'S NAME <b>Charles J. McCloskey</b>				14. MOTHER'S MAIDEN NAME <b>Myra C. Calloway</b>				12. CITIZEN OF WHAT COUNTRY? <b>yes</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Cornelius Donnelly Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Lobar Pneumonia</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral carcinoma of breast</b> DUE TO (c) <b>Metastatic breast carcinoma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 21</b> , 19 <b>65</b> , to <b>March 20</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>March 20</b> 19 <b>66</b> , and that death occurred at <b>4:30</b> p.m., from the causes and on the date stated above.											
22a. SIGNATURE <b>Harry N. Carlton</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22b. DATE SIGNED <b>March 21, 1966</b>											
22c. PHYSICIAN'S NAME (Type) <b>HARRY N. CARLTON</b> 22d. ADDRESS <b>909 Pershing Dr. Silver Spring, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Silver Spring, Md.</b>			
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Bethesda, Md.</b>						25a. REC'D BY REGISTRAR <b>MAR 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03935

03925

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San &amp; Hosp.</u>		d. STREET ADDRESS <u>6215 41st. Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Gertrude</u> Last <u>Donovan</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-87</u>
9. AGE (In years last birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>William Miller</u>		14. MOTHER'S MAIDEN NAME <u>Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>718-10-5360</u>	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition &amp; weakness</u> 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Inadequate intake of food</u> DUE TO (c) <u>Adenoid cystic carcinoma of mouth &amp; tongue</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>4 mo</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 26, 1966</u> to <u>March 1, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 1, 1966</u> , and that death occurred at <u></u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred W. Eastman</u>		22b. DATE SIGNED <u>March 2, 1966</u>	
22c. PHYSICIAN'S NAME <u>Alfred W. Eastman, M.D.</u>		22d. ADDRESS <u>1200 Prospect Ave. Takoma Pk, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/4/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>BETHESDA, MD.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 7 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2003

DEPARTMENT OF JUSTICE

GOVERNMENT

7-10-1960

NO

UNITED STATES DEPARTMENT OF JUSTICE  
1200 Maryland Ave. N.W.  
Washington, D.C. 20004



Dr. Resp. 1 notified  
3/27/66  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03936 CERTIFICATE OF DEATH 03926

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>14302 Merton Court</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>15-1</u>			
				d. STREET ADDRESS <u>14302 Merton Court</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Lottie B. Dookan</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22, 1894</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTH PLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Russell Davis</u>				14. MOTHER'S MAIDEN NAME <u>Birtie Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Jacqueline B. Fowler</u>				Address <u>14302 Merton Ct. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>hour</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June, 1963</u> , to <u>March, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/16</u> 19 <u>66</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. Lenard Gold</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lenard Gold</u>				22d. ADDRESS <u>8641 Colesville Rd., Silver Sp.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>30 March 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ceder Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>MAR 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 2 Film G375 4/11/66 mh  
**CERTIFICATE OF DEATH**

03937

03927

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b <u>11/11/1947</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington Silver Spring 15-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carol Hall Nursing Home</u>				d. STREET ADDRESS <u>10231 Carol Hall Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MYRTIS</u> Middle <u>DREKA</u> Last <u>DREKA</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>30</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 20, 1886</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Nurse</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Nova Scotia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Miller</u>				14. MOTHER'S MAIDEN NAME <u>Maggie McPhee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Bertha D. Dale 106 E. 42nd Street Wilm. Dela</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>FEB. 4</u> , 1966, to <u>MARCH 30</u> 1966, that (I) (we) last saw the deceased alive on <u>MARCH 30</u> 1966, and that death occurred at <u>4:45</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Hendry London</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert E. Wellholer</u>				22d. ADDRESS <u>5206 Norway Dr Chesapeake, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-2-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Old Drawyers</u>		23d. LOCATION (City or Town) (County) (State) <u>Odessa Delaware</u>	
24. FUNERAL DIRECTOR <u>Robert E. Wellholer</u>				ADDRESS <u>4308 Sutherland Rd Sutherland Md</u>		25a. REC'D BY REGISTRAR <u>APR 4 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16250

5206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4307 Chestnut St.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>4307 Chestnut Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Martha</b>			First <b>B.</b>		Middle <b>DuBois</b>		Last <b>DuBois</b>		4. DATE OF DEATH <b>March 3, 1966</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/30/17</b>		9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR <b>4</b> Months <b>3</b> Days IF UNDER 24 HRS. <b>15</b> Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Drayton N. Barksdale</b>					14. MOTHER'S MAIDEN NAME <b>Emma Hilley</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>4307 Chestnut Street Robert DuBois Chevy Chase, Md.</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial asthma</b> <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> , to <b>MAR 3</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb 26</b> , 19 <b>66</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Wesley M. Oler, M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>MARCH 3, 1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>WESLEY M. OLER</b>						22d. ADDRESS <b>1150 Conn. Av. N.W. WASHINGTON D.C.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/7/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>			23d. LOCATION (City, town or county) <b>Washington, D.C.</b> (State) _____					
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Bethesda, Md.</b>						25a. REC'D BY REGISTRAR <b>DATE MAR 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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107 Chestnut Street

Dubois

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Georgia

Emma Kelley

107 Chestnut Street  
Robert Dubois Gray Chase, Md.

1938

Montgomery

Gray Chase

107 Chestnut St.

Montgomery

Chase

Montgomery

Gray Chase, Maryland

to

Robert A. Montgomery, Maryland.

Montgomery, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

039329

## CERTIFICATE OF DEATH

03929

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Fulton</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>2 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>				e. STREET ADDRESS <b>2092 West Mercer Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Gina</b> Middle <b>Marie</b> Last <b>Duckett</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 December 1957</b>	9. AGE (In years last birthday) <b>8</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>24</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Months <b>8</b> Days <b>24</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Morgan Duckett, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Joyce Louise Cheeks</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b> <b>2893</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cystic Fibrosis of the pancreas</b> DUE TO (c) <b>8 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>22 March</b> , 19 <b>66</b> , to <b>24 March</b> , 19 <b>66</b> , that (b) (we) last saw the deceased alive on <b>24 March</b> , 19 <b>66</b> , and that death occurred at <b>1015</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert H. Schwartz, M.D.</b>				22b. DATE SIGNED <b>25 March 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert H. Schwartz, M.D.</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>3-25-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Atlanta, Georgia</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Frozen Funeral Home</b>		24a. ADDRESS <b>Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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English

Georgia

Montgomery

College Park

2 Days

Johnson

The Clinical Center, Bethesda 14, Maryland 2082 West Hurst Avenue

March 24 1957

31 December 1957

U.S.A. Georgia Bone

Joyce Louise Glick

The Medical Research

The Clinical Center, Bethesda 14, Maryland

Bone

No

Respiratory Infection

2 days

(Type I) Virus of the parotid

5 years

March 24 1957

March 24 1957

X 15 March 1957

The Clinical Center, National

Institute of Health, Bethesda 14, Md.

Robert H. Schwartz, M.D.

STANLEY E. COHEN

March 24 1957

March 24 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
03940									
03930									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. LENGTH OF STAY IN 1b <u>60 Days</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				
					d. STREET ADDRESS <u>1114 Dunoon Road</u>				
3. NAME OF DECEASED (Type or print) <u>DOROTHY WAY DUNCAN</u>					4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6 Oct 1922</u>		9. AGE (In years last birthday) <u>43</u> yrs.	
								IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sec.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Ordinance La.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Phila., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John C. Lander</u>					14. MOTHER'S MAIDEN NAME <u>Eleanor Raiser</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Rev. James O. Duncan</u>		Address <u>1114 Dunoon Road Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X</u> <u>INANITION &amp; ACUTE URINARY TRACT INFECTION</u> DUE TO (b) <u>METASTATIC CARCINOMA OF LEFT BREAST</u> DUE TO (c) <u>FEB. '64</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> , 19 <u>62</u> , to <u>DEATH</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>3/29</u> 19 <u>66</u> , and that death occurred at <u>5:14</u> A.M., from the causes and on the date stated above.									
22a. SIGNATURE <u>Henry R. Wolfe</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/30/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Henry R. Wolfe</u>					22d. ADDRESS <u>905 Sheriden St., Adelphia, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1 April 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co., Md.</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
Dr. Reap Called - CERTIFICATE OF DEATH 03931													
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>12 Hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHEV CHASE</u> d. STREET ADDRESS <u>7107 LENHART DR.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED <u>Sacket</u> First Middle Last (Type or print) <u>L. Duryee</u>						4. DATE OF DEATH <u>MARCH 23 1966</u> Month Day Year							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1880 12-8-89</u> yrs. Months Days		9. AGE (In years last birthday) <u>85</u> yrs. Months Days		10. IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Adm. Asst.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Army Engineering Off. Washington D.C.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Sacket Duryee</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-32-4508</u>		17. INFORMANT <u>Mrs. Arthur Smith</u>		Address <u>7107 Lenhart Drive Chevy Chase, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>4201</u> DUE TO <u>Myocardial Ischemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis, General</u> (c) <u>20 yrs.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 Minute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure, Anemia</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 3, 1965</u> to <u>March 23 1966</u> , that (I) (we) last saw the deceased alive on <u>March 22 1966</u> , and that death occurred at <u>9:42 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>George B. Patrick Jr.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-23-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>George B. Patrick Jr.</u>						22d. ADDRESS <u>9221 Colesville Road, S. S., Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>26 March 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George's Co., Md.</u>							
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>							

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George A. ...  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03942 CERTIFICATE OF DEATH 03932									
1. PLACE OF DEATH a. CDUNITY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Florida</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>35 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Opa-locka</b> 48-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>					d. STREET ADDRESS <b>3260 N.W. 176th Terrace</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anita Marie Ebanks</b>			First Middle Last		4. DATE OF DEATH <b>March 14 1966</b>		Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 October 1931</b>		9. AGE (In years last birthday) <b>34</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>William Allen</b>					14. MOTHER'S MAIDEN NAME <b>Estelle Tryon</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>Not Available</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Md. 20014</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub-arachnoid Hemorrhage</b> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>  <b>1 1/2 years</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>D</b> (this hospital) attended the deceased from <b>February 7, 1966</b> , to <b>March 14, 1966</b> , that <b>I</b> (we) last saw the deceased alive on <b>March 14, 1966</b> , and that death occurred at <b>3:00 P.M.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Herman A. Godwin, Jr.</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>14 March 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herman A. Godwin, Jr., M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-18-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Flagler Memorial Park</b>			23d. LOCATION (City, town or county) (State) <b>Miami Florida</b>		
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>					ADDRESS <b>4308 Suitland Rd Suitland Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

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FOR STATE HEALTH DEPT.

03948

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03933

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK, MD.</b>		c. LENGTH OF STAY IN lb <b>25 hr. 26 min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 15-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM + Hospital</b>				d. STREET ADDRESS <b>912 Langley Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alvin</b> Middle <b>Theodore</b> Last <b>Engstrom</b>				4. DATE OF DEATH Month <b>3</b> Day <b>14</b> Year <b>19 66</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-14-07</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>14</b> Hours <b>19</b> Min. <b>66</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED POLICEMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>METRO POLICE FORCE</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLAUS ENGSTROM</b>				14. MOTHER'S MAIDEN NAME <b>ELLA FRISK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-36-0574</b>		17. INFORMANT <b>Langley Engstrom Hospital Records</b> Address <b>912 Langley Drive Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X</b> <b>Cardiac arrest following surgical repair</b> DUE TO (b) <b>of ruptured abdominal aortic aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>with hemorrhage.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b>		EXAMINER'S NAME (Type) <b>Belden Reap Wheaton, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 18, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Falls Church, Virginia</b>	
24. FUNERAL DIRECTOR <b>Glank &amp; Winer</b>		ADDRESS <b>8434 Georgia Ave</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
Warner E. Humphrey, Inc.		Silver Spring, Md.		DATE <b>MAR 21 1966</b>			

5495

PAGE

FOR STATE  
 HEALTH DEPT.

03944

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03934

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>North Carolina</i> ✓ b. COUNTY <i>Fairmont</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>70-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San. &amp; Hospital</i>		d. STREET ADDRESS <i>209 Oakwood St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Wayne</i> Middle <i>Faulk</i> Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month <i>3</i> Day <i>28</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-1-20</i>
9. AGE (In years last birthday) yrs. <i>46</i>		10. IF UNDER 1 YEAR Months <i>46</i> Days <i>46</i> Hours <i>46</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DRIVER BORO - TRUCKING CO.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FAIRMOUNT, N. CAR.</i>	
11. BIRTHPLACE (State or foreign country) <i>FAIRMOUNT, N. CAR.</i>		12. CITIZEN OF WHAT COUNTRY? <i>BAITIMORE 16 md.</i>	
13. FATHER'S NAME <i>Wilmer FAULK</i>		14. MOTHER'S MAIDEN NAME <i>MAY FLOYD</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes W.W.II</i>		16. SOCIAL SECURITY NO. <i>Mr. Jasper Faulk</i>	
17. INFORMANT <i>brother</i>		Address <i>3715 Woodhaven Ave.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> <i>Acute coronary insufficiency</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i> EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		22. DATE SIGNED <i>March 28, 1966</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4-1-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Church Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Fairmont, North Carolina</i>
24. FUNERAL DIRECTOR <i>Washington Funeral Chapel</i>		25a. REC'D BY REGISTRAR <i>APR 7 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03945

## CERTIFICATE OF DEATH

03935

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN 1b <u>69 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> <u>83-3</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				d. STREET ADDRESS <u>3201 North Vermont Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Josephine Tarbell FERRELL</u>				4. DATE OF DEATH Month Day Year <u>March 7 19 66</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 27, 1890</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Boston, Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Edmund Tarbell</u>				14. MOTHER'S MAIDEN NAME <u>Emaline Souther</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Virginia</u> <u>Mrs. John W. McLain Ferlain Farms, Madison/</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the bladder</u> <u>1810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 28</u> , 19 <u>65</u> , to <u>Mar. 7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Mar. 7</u> , 19 <u>66</u> , and that death occurred at <u>630AM</u> , from causes and on the date stated above.								
22a. SIGNATURE <u>Edward C. Gilbert</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Gilbert, M.D.</u>				22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-10-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>				
24. FUNERAL DIRECTOR <u>1500 West Braddock Road, Alexandria, Va.</u> <u>Everly-Wheatley Funeral Home, /Alexandria, Va.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

113935

UNIT HEAD IN DEATH

113935

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03946

03936

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium 10231 Carroll Place				d. STREET ADDRESS 3918 Jenifer St. N.W.			
3. NAME OF DECEASED (Type or print) NINA FLAUME				4. DATE OF DEATH MARCH 5 1966			
5. SEX 7	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/84	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Victor Merjeyevsky			
14. MOTHER'S MAIDEN NAME Maria Stroganov				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -----			
16. SOCIAL SECURITY NO. -----				17. INFORMANT Ethel Flaume same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTEROSCLEROSIS & HYPERTENSION DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURED Hip SEPT 1965 Completely Healed - PT up & walking							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 1965, to MARCH, 1966, that (I) (we) last saw the deceased alive on MARCH 2, 1966, and that death occurred at 8:40 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Sarah E. Glover				22b. DATE SIGNED 3-5-66		22c. PHYSICIAN'S NAME (Type) SARAH E. GLOVER M.D.	
22d. ADDRESS 10128 CEDAR LANE KENSINGTON				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3/8/66		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR A. Hines Co. 2901 14th NW, D.C.				25a. REC'D BY REGISTRAR MAR 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

03230

03230



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. **M**

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03947

03937

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase -</u>		c. LENGTH OF STAY IN ID <u>years.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6402 Ruffin Rd.</u>		e. STREET ADDRESS <u>6402 Ruffin Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>L</u> Middle <u>Furbershaw</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/8/1886</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR <u>1</u> Months <u>25</u> Days <u></u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Furbershaw</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lawton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>213-38-2085</u>	
17. INFORMANT <u>Miriam Furbershaw</u>		18. ADDRESS <u>6402 Ruffin Rd. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4201</u> DUE TO (b) <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/3/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3/4/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR <u>Charles Judy</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judy</u>	

15825

3047

Medicine

James J. Thompson

Harry Linton

One

213-28-3003 Hiram Thompson

6-02 Ruffin Rd.

213-28-3003 Hiram Thompson

John G. Hall, M.D.

James J. Thompson

John G. Hall, M.D.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

03948

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03938

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville.</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>263 Congressional Lane.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dean.</u> Middle <u>-</u> Last <u>Gallagher</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26 1897</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Credit Assn.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick. Gallagher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Dean.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-144509</u>	
17. INFORMANT <u>W. Edward Gallagher</u>		Address <u>2018 Lanier Dr., S.S., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke Inhalation -</u> <u>9/60</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fire in Apartment.</u> DUE TO (c) <u>30 min.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cirrhosis of Liver.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>Sat Fire to Chair while smoking -</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:30 a.m. 3/29 19 66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>apartment -</u>		20f. (City or town) (County) (State) <u>Rockville Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
<u>Bethesda, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>3/30/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/31/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR <u>John E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Ga. Ave., S.S., Md.</u>	
25a. REC'D BY REGISTRAR <u>APR 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

20

2103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA Chase</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON --Rural 15-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BETHESDA-SILVER SPRING NURSING HOME</u>						d. STREET ADDRESS <u>9910-WILDWOOD ROAD</u>					
3. NAME OF DECEASED (Type or print) <u>EDITH D. GAYMAN</u>						4. DATE OF DEATH <u>Mar. 22, 1966</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-13-1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>OHIO (Franklin County)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN DECKER</u>						14. MOTHER'S MAIDEN NAME <u>ADA L. DOHERITY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes give war or dates of service) <u>-</u>						16. SOCIAL SECURITY NO. <u>295-40-5462</u>		17. INFORMANT <u>WENDELL P. Gayman (SEE ITEM 2 ABOVE)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> <u>334X</u> DUE TO (b) <u>DEHYDRATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CEREBRAL ARTERIOSCLEROSIS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>1 wr.</u> <u>12 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>DIABETES MELLITUS</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> , 19 <u>64</u> , to <u>22, Mar</u> , 19 <u>66</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>22 Mar</u> 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Horace Wright Bernton</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/22/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Horace Wright Bernton</u>						22d. ADDRESS <u>4743 Bradley Blvd., Chevy Chase, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>3-24-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Obetz Lutheran Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Obetz, Ohio</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MAR 24 1966

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Spokane, Idaho

U.S. (DC)

Removal

March 1, 1968

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03950

03940

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5103 Brentford Rd.</u>		d. STREET ADDRESS <u>5103 Brentford Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Martha</u> First Middle Last		4. DATE OF DEATH <u>March 7</u> 19 <u>66</u> Month Day Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/6/1886</u> 79 yrs. 4 Months 31 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wrapping Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
13. FATHER'S NAME <u>Herman Wolf</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Montog</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>143-05-3429</u>	
17. INFORMANT <u>Mrs. Gordon. Same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4201</u> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>3/7/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>3-10-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach to the certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03951

03941

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>8 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>#5 SILVER SPRING 15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH SANITARIUM &amp; HOSP</u>				d. STREET ADDRESS <u>17915 TAKOMA STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE BYRON GERNARD</u>				4. DATE OF DEATH <u>3</u> <u>22</u> <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-82</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF FUNER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Realator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Realestate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown GERNARD</u>				14. MOTHER'S MAIDEN NAME <u>Unknown HARRIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>313-34-9422</u>		17. INFORMANT <u>Wm. D. Gerhard</u> Address <u>9715 Takoma Avenue Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u> 4341 DUE TO <u>Electrolyte imbalance (hypochloremia)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>alcoholic</u> DUE TO <u>Congestive heart failure, uremia</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u> <u>4 days</u> <u>8 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>March 14, 1966</u> to <u>March 22, 1966</u> , that (2) (we) last saw the deceased alive on <u>March 22, 1966</u> , and that death occurred at <u>6:04 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James R. Coleman MD.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 22, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>				22d. ADDRESS <u>9241 Columbia Blvd. Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Wayne, Indiana</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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*Calceolaria*  
*Chelidonium*  
*Cypripedium*  
*Delphinium*  
*Erythronium*  
*Galium*  
*Geranium*  
*Helleborus*  
*Hyacinthus*  
*Impatiens*  
*Linum*  
*Lupinus*  
*Nigella*  
*Ornithogalum*  
*Pulsatilla*  
*Ranunculus*  
*Scilla*  
*Thalictrum*  
*Urtica*  
*Veronica*  
*Viola*  
*Yucca*

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03952

113942

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>906 Stone St</u>	
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>GILES</u> Last <u>GILES</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>R</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 30 1894</u>
9. AGE (In years <u>71</u> yrs)		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>BROOKVILLE Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Washington Swailes</u>		14. MOTHER'S MAIDEN NAME <u>Susie Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(51564)</u>	
17. INFORMANT <u>EMILY M HARRIDAY</u>		Address <u>Rockville 915 Stone St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation. Acute.</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiovascular Disease</u> DUE TO (c) <u>Chronic Rheumatic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>obesity</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/3/66	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/6/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Mt. Zion Montg Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
25a. REC'D BY REGISTRAR <u>MAR 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San + Hosp.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8813 Reading Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Archibald</u> First <u>unm</u> Middle <u>Gill</u> Last						<b>4. DATE OF DEATH</b> <u>Mar.</u> Month <u>20</u> Day <u>1966</u> Year							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 2, 1888</u>		<b>9. AGE</b> (In years last birthday) <u>77</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Domestic.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Aspen, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>James Gill</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Raney</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs. Annie Gill - wife</u> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Coronary Sclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis-</u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 hrs</u> <u>10 yrs.</u> <u>20 yrs</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/18, 1937</u> , <b>to</b> <u>3/20, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>3/20, 1966</u> , <b>and that death occurred at</b> <u>3:05</u> <b>M.</b> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>N.E. Shoemaker M.D.</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3/20/66</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>N.E. Shoemaker M.D.</u>						<b>22d. ADDRESS</b> <u>871 Dale Drive Silver Spring, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>March 23, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gate of Heaven</u>				<b>23d. LOCATION (City, town or county)</b> (State) <u>Silver Spring, Maryland</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Warner E. Pumphrey, Inc.</u>						<b>ADDRESS</b> <u>8434 Georgia Avenue</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 24 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "and", "the", "of" are faintly visible.]*

*[Faint handwritten text at the bottom of the page, possibly a signature or date.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03944

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONT.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>since 1940</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>802 WAYNE AVENUE</u>		d. STREET ADDRESS <u>802 WAYNE AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BAILEY</u> Middle <u>A.</u> Last <u>GLADMON</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1, 1888</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - PRESSMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, D. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>RUDOLPH GLADMON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH MITCHELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-54-3661</u>	
17. INFORMANT <u>MRS. EMMA A. GLADMON SAME AS #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4500</u> (c) <u>154RS.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/23 1959</u> to <u>MARCH 1 1966</u> that (I) (we) last saw the deceased alive on <u>MARCH 1 1966</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James A. Roberts</u>		22b. DATE SIGNED <u>MARCH 1, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		22d. ADDRESS <u>8907 GEO. AVE. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-4-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GATE-OF-HEAVEN</u>		23d. LOCATION (City, town, or county) (State) <u>SILVER SPRING, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		25a. REC'D BY REGISTRAR <u>MAR 3 1966</u>	
ADDRESS <u>WASH. D. C. 3821 14TH. ST. N. W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03955		03945	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> D.C. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>4103-W St., N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Herschel W. Glass</u>		4. DATE OF DEATH <u>March 27</u> 19 <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/06</u> 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>	
13. FATHER'S NAME <u>James Quincy Glass</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Freda Wiesenmyer Glass</u>		Address <u>- See Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular + failure</u> <u>260x</u> DUE TO (b) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes mellitus severe</u> <u>amputation of left leg</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1 - severe aneurysm</u> <u>2 - pulmonary infection</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-1</u> , 19 <u>65</u> , to <u>3-27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-27</u> , 19 <u>66</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Veronika Troost</u>		22b. DATE SIGNED <u>3-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Veronika Troost, M. D.</u>		22d. ADDRESS <u>10236 New Hampshire Ave., S.S. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>3-30-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Union Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Macon, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Joseph Gawler's Sons, Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>MAR 31 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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08252

Montgomery

Washington

D.C.

Oliver Spring / Smith Ave

Holy Cross Hospital

4103 - W St, N.W.

Therese M. Glass

March 22

Male white

7/26/66

Electrocardiogram

Monoclonal

U.S.A.

Veronica Frost, N. D. 10308 New Horton Ave., S.W.

Novel 1-2-1000 Union of New Cemetery Road, N.W.

Joseph Gaudin, D.O. 411 21 Ave. N.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film G375 4/4/66 mh

03956

CERTIFICATE OF DEATH

03946

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>OHIO</b> b. COUNTY <b>Marion</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (rural)</b>			c. LENGTH OF STAY IN TB <b>172 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion</b> 72-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital Bethesda, Maryland</b>				d. STREET ADDRESS <b>150 Boone Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>John</b> Last <b>GOODMAN, III</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 AUG 1944</b>	
9. AGE (In years last birthday) <b>21</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USMC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Princeton, Gibson, Ind.</b>	
13. FATHER'S NAME <b>Frank GOODMAN,</b>				14. MOTHER'S MAIDEN NAME <b>Virginia ROBBS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>521-58-5454</b>		17. INFORMANT <b>Francis J. GOODMAN</b> Address <b>Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>177X</b> (b) <b>Adenocarcinoma of the prostate</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>4 OCT</b> , 19 <b>65</b> , to <b>25 MAR</b> , 19 <b>66</b> , that <b>he</b> (we) last saw the deceased alive on <b>25 MAR</b> , 19 <b>66</b> , and that death occurred at <b>1:00 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Lawrence A. Jones</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>25 MAR 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence A. Jones</b>				22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Highland Memorial Cemetery Mt. Carmel, Illinois</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS, 1400 Chapin St., Wash., D.C.</b>				25a. REC'D BY REGISTRAR <b>28 MAR 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03957

103947

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>46 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leesburg</b>		83.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>113 Daniels Street</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charlotte</b> Middle <b>H.</b> Last <b>GOODNOW</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1919</b>
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Odessa, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward T. Halpin</b>		14. MOTHER'S MAIDEN NAME <b>Mary Middlebrook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>061-18-6791</b>	
17. INFORMANT <b>Mr. Harold J. Goodnow, 113 Daniels St./</b>		Address <b>Leesburg, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute peritonitis</b> <b>578X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bowel resection</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 11</b> , 19 <b>66</b> , to <b>Mar. 30</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Mar. 30</b> , 19 <b>66</b> , and that death occurred at <b>7:45 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>P. B. Blanchard</b>		22b. DATE SIGNED <b>Mar. 30, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>P. B. Blanchard, M. D.</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 3/31/66</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Odessa, New York</b>	
24. FUNERAL DIRECTOR <b>R. A. Pumphrey Funeral Home</b> <b>7557 Wisconsin Ave., Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 4 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Body released by Dr. Kemp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03958 Item 8 Film 0575 4/2/66 md											
03948											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOLY CROSS</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>7611 GEORGIA AVE #204</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b> First <b>L.</b> Middle <b>GRANT</b> Last			4. DATE OF DEATH <b>3</b> Month <b>29</b> Day <b>1966</b> Year			5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>4-5-1881</b> 9. AGE (In years last birthday) <b>84</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Asbestos Installer</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Joseph L. Grant</b>						14. MOTHER'S MAIDEN NAME <b>Josephine Mace</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>578-03-0635</b>			17. INFORMANT <b>Duanette A. Grant N. W.</b>			Address <b>7611 Georgia Ave., # 204</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA BILATERAL ACUTE</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>3-26</b> , 19 <b>66</b> , to <b>3/29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-28</b> , 19 <b>66</b> , and that death occurred at <b>6:25</b> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <b>Samuel A. Hillman</b> 22c. PHYSICIAN'S NAME (Type) <b>Samuel A. Hillman</b>						22b. DATE SIGNED <b>3-29-66</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1 April 1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Prince George County, Md.</b>		
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b> ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>						25a. REC'D BY REGISTRAR <b>MAR 31 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03953

03949

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4757 Cherry Chase Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Anna</u> Last <u>Groves</u>		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5 - 1895</u>
9. AGE (In years last birthday) <u>70</u>		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>16</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Ralls</u>		14. MOTHER'S MAIDEN NAME <u>Alice A. Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>W.W.T.</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Sister (Helen Lingbock)</u>		Address <u>-</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute -</u> DUE TO (b) <u>Cardio Vascular Disease -</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>3/16/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>												
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>39 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>						<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>8513 Flower Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <u>Lenora</u> <u>Jemimah</u> <u>Grogg</u>			<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>23</u> Year <u>1966</u>			<b>5. SEX</b> <u>Female</u>			<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>8-5-88</u>			<b>9. AGE (In years last birthday)</b> <u>77</u> yrs.			<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>Housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>DOWN HOME</u>			
<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>West Virginia</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			<b>13. FATHER'S NAME</b> <u>Solomon Perry</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Jemimah Perkins</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>			<b>17. INFORMANT</b> <u>Records Washington San &amp; Hospital</u>			<b>Address</b>			
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>260x</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Diabetes mellitus</u>												
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>												
<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>												
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>				
<b>20f. (City or town)</b>				<b>(County)</b>				<b>(State)</b>				
<b>21. I certify that (I) (this hospital) attended the deceased from <u>March 1</u>, 19<u>66</u>, to <u>March 23</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>March 22</u>, 19<u>66</u>, and that death occurred at <u>1:00</u> P.M. from the causes and on the date stated above.</b>												
<b>22a. SIGNATURE</b> <u>Bros Robbin</u>						<b>22b. DATE SIGNED</b> <u>3/23/66</u>						
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Bros Robbin</u>						<b>22d. ADDRESS</b> <u>1019 Univ. Blvd, East Silver Spring, Md.</u>						
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>26 March 1966</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Haffner</u>				
<b>23d. LOCATION (City, town or county)</b> <u>White Sulphur Springs, W. Va.</u>				<b>(State)</b>				<b>25a. REC'D BY REGISTRAR</b> <u>MAR 28 1966</u>				
<b>24. FUNERAL DIRECTOR</b> <u>Warner E. Pumphrey, Inc.</u>						<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>						

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MAR 2 1960

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

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03951

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY in 1b <u>4 days</u>		d. STREET ADDRESS <u>5922 Conway Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>JOHN</u> Last <u>HAAS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-15-21</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HAAS + CLARK INC</u>	9. AGE (In years last birthday) <u>44</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>STATEN ISLAND N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Richard Henry Haas</u>		14. MOTHER'S MAIDEN NAME <u>Leopoldine Boeck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>132-07-0003</u>	
17. INFORMANT <u>Madeline L. Haas</u>		Address <u>Same as Item 2.</u> <u>ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic glomerulonephritis with uremia</u> DUE TO (b) <u>myocardial infarction</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>66</u> , to <u>31 March</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>31 March</u> 19 <u>66</u> , and that death occurred at <u>940 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John M. Wyman</u>		22b. DATE SIGNED <u>4/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John M. Wyman</u>		22d. ADDRESS <u>7801 Norfolk Ave., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-4-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George Co., Md.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>APR 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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APR 7 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH																													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																													
CERTIFICATE OF DEATH																													
03952																													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>																								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>					c. LENGTH OF STAY IN 1b <u>9 days</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>					d. STREET ADDRESS <u>Rt. 2 Box 169</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Marie</u> Last <u>Hampton</u>					4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1966</u>																								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/20/09</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>														
13. FATHER'S NAME <u>Henry Scheeler</u>					14. MOTHER'S MAIDEN NAME <u>Emma Metzger</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>?</u>					17. INFORMANT <u>Mr. James A. Hampton</u> Address <u>above</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4201 DUE TO (b) <u>Arteriosclerotic Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Rheumatic heart disease with aortic stenosis and insufficiency</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatic heart disease with aortic stenosis and insufficiency</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>3-1-66</u> , 19 <u>  </u> , to <u>3-10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Mar. 9</u> 19 <u>66</u> , and that death occurred at <u>6A</u> M, from the causes and on the date stated above.															22a. SIGNATURE <u>Frederick Moomau</u> M.D.					22b. DATE SIGNED <u>Mar. 10, 1966</u>									
22c. PHYSICIAN'S NAME (Type) <u>Dr. Frederick Moomau</u>															22d. ADDRESS <u>Medical Center, Sandy Spring, Md.</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>3-12-66</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial</u>					23d. LOCATION (City, town or county) (State) <u>Sykesville Carroll Co. Md.</u>														
24. FUNERAL DIRECTOR <u>Harry W. Haight</u> <u>Sykesville, Md.</u>															25a. REC'D BY REGISTRAR <u>Charles Judge</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

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3/4/66 7:35 a.m. Cleared with Medical Examiner, Dr. Reap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The page should be removed from the certificate and placed in the funeral director's file. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b></span>						<b>2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)</b> a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span>					
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>						d. STREET ADDRESS <b>12224 Selfridge Road</b>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>First Middle Last</b> <b>Austin L. Harris</b>						<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>4</b> Year <b>19 66</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>April 24, 1905</b>		<b>9. AGE (In years last birthday)</b> <b>60 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Mins. <b>0</b>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Bakery</b>				<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <b>Virginia</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>James A. Harris</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth F. Chamdler</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, No, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Son-in-law: James Toman</b>					
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Pulmonary Edema</b> <b>4200</b> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>(b) Coronary Heart Failure Left Vent.</b> <b>(c) Arterio-sclerotic heart disease</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Emphysema</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>15 Jan</u>, 19<u>66</u>, to <u>9 March</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>11 Feb</u>, 19<u>66</u>, and that death occurred at <u>7:50 P.</u> from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>Merton L. White</b>						<b>22b. DATE SIGNED</b> <b>4 March 66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Merton L. White</b>		<b>22d. ADDRESS</b> <b>9911 Georgia Ave S576</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>3/6/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Vernon</b>		<b>23d. LOCATION (City, town or county)</b> <b>Augusta Co. Virginia</b>		<b>(State)</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Tyson Wheeler</b>						<b>25a. REC'D BY REGISTRAR</b> <b>MAR 7 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

8035

Montgomery

Silver Soling

Holy Cross Hospital

243 J. 17A

1999

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66

201-11-102 : 11-11-102

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03964

03954

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>61 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u> d. STREET ADDRESS <u>2722 Dawson Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Beulah G Harrison</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>16<sup>th</sup></u> Year <u>1966</u>		<b>5. SEX</b> <u>Female</u>			
<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Mar 13<sup>th</sup> - 1872</u>			
<b>9. AGE</b> (In years last birthday) <u>94 yrs.</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>3</u>		<b>11. IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Concert Singer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Music</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Frederick Gaylord</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Carrie Vaughn</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>140-24-2376</u>		<b>17. INFORMANT</b> <u>Mr. Henry Young</u> Address <u>2722 Dawson Ave.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>442X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause } (b) <u>Hypertensive C-V-Renal</u> (a), stating the underlying cause last. } DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> <u>11/14/66</u>		<b>20g. (County)</b> <u>66</u>		<b>20h. (State)</b> <u>3/16/66</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11/14/66</u> <b>to</b> <u>3/16/66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>3/16/66</u> , <b>and that death occurred at</b> <u>66</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>C.H. Young</u>		<b>22b. DATE SIGNED</b> <u>3/16/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>C.H. Young</u>			
<b>22d. ADDRESS</b> <u>Sandy Spring, Md.</u>		<b>22e. MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/19/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Methodist Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>New Providence</u>		<b>23e. (State)</b> <u>New Jersey</u>					
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>		<b>24a. ADDRESS</b> <u>Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 21 1966</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03354

CERTIFICATE OF DEATH

03354

New Providence New Jersey

Methodist Cemetery

3/1/88

Burial

Robert A. Humphrey Bethesda, Maryland

March 1 1888

Wm. J. ...

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03965

CERTIFICATE OF DEATH

03955

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				d. STREET ADDRESS <u>4202 Tuckerman Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Mary</u> Last <u>Kennedy</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>19 66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9, 1903</u>		
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah Kennedy</u>				14. MOTHER'S MAIDEN NAME <u>Jessica Jackson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Univ. City Park, Md.</u> <u>Mrs. Elizabeth Walsh, 4202 Tuckerman St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchial pneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (X) (this hospital) attended the deceased from <u>Mar. 21</u> , 19 <u>66</u> , to <u>Mar. 23</u> , 19 <u>66</u> , that (X) (we) last saw the deceased alive on <u>Mar. 23</u> , 19 <u>66</u> , and that death occurred at <u>300A</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>J. B. EMERY, M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Mar. 23, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>J. B. EMERY, M.D.</u>				22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery, Arlington, Virginia</u>		23d. LOCATION (City or Town) (County) (State) <u>  </u>		
24. FUNERAL DIRECTOR <u>Francis Gasch's Son</u> <u>4739 Baltimore Ave., Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03822

REPUBLIC OF CHINA

03822

MAR 28 1960



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

1 (M)

03966

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03956

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington San + Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>318 Wayne Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Docia Earl Hatcher</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-21-1900</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William D. Krouse</b>				14. MOTHER'S MAIDEN NAME <b>Mary Cartwright</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-30-628</b>		17. INFORMANT <b>Daughter</b> Address <b>318 T. Wayne Ave. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>Present</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-2</b> 19 <b>66</b> , and that death occurred at <b>10:30</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Abraham W. Danish</b>				22b. DATE SIGNED <b>3-10-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>ABRAHAM W. DANISH</b>				22d. ADDRESS <b>1106 Spring St. S.S.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 14, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>MAR 15 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				25c. ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>			

MEDICAL CERTIFICATION

BP

Charles E. Medical Examiner



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03967

03957

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sylvan Manor Health Care Center</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> <span style="float: right;">b. COUNTY <u>Prince Georges</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u> d. STREET ADDRESS <u>3809-64th Ave. Landover Hills</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Sadie</u>		First Middle Last <u>Heisner</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>March 18 1966</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Wh.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>June 12, 1884</u>		<b>9. AGE</b> (In years last birthday) <u>82</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours Min.						
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S.A.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Austria</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Harry Bick</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Minnie</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NO</u>		<b>17. INFORMANT</b> <u>George Harris</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer right lungs</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic Cardiovascular disease</u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>1-16</u>, 19<u>66</u>, to <u>3-18</u>, 19<u>66</u>; that (I) (we) last saw the deceased alive on <u>3-18</u>, 19<u>66</u>, and that death occurred at <u>8:00</u> M., from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Morris Perry</u>		<b>22b. DATE SIGNED</b> <u>3-18-66</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Morris Perry</u>			
<b>22d. ADDRESS</b> <u>11602 La. Ave. S.D. Md</u>		<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/20/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ring David M. New London Falls Church, Va.</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Wash. D.C.</u>		<b>23e. REC'D BY REGISTRAR</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>B. H. Gaugan</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>24c. DATE</b> <u>MAR 22 1966</u>			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

10284

5821

1891

1 (M)

EXAMINER  
DR. DEAN (M.D.)

CLEARED BY DEPUTY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(I)

03968

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03958

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>8 YRS.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>F</b> Last <b>HELLER</b>				4. DATE OF DEATH Month <b>MAR</b> Day <b>31</b> Year <b>1966</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-18-09</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SIGMUND FRIEDMAN</b>				14. MOTHER'S MAIDEN NAME <b>SARAH LAZERSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSION</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>ONE HOUR</b> <b>8 YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , 19 to <b>3-31-</b> , 1966, that (I) (we) last saw the deceased alive on <b>Mar 31</b> 1966, and that death occurred at <b>7:00 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert Kramer</b>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Mar 31, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert Kramer</b>				22d. ADDRESS <b>8484 16th ST. Silver Spring Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-3-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATH'L MEM. PARK</b>		23d. LOCATION (City, town or county) (State) <b>FALLS CHURCH, VA</b>	
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b> ADDRESS <b>4217-9th St</b>				25a. REC'D BY REGISTRAR <b>APR 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Robert H. Kline

APR 1 1957



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03969		03959	
1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodacres,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodacres</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6 Ardmore Circle</b>		d. STREET ADDRESS <b>6 Ardmore Circle</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis Louis Henley</b>		4. DATE OF DEATH Month Day Year <b>March 24 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1908</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Potomac Elec. Co. Dist. of Col.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Wilson T. Henley,</b>		14. MOTHER'S MAIDEN NAME <b>Anne Port</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No -</b>		16. SOCIAL SECURITY NO. <b>577 05 0150</b>	
17. INFORMANT <b>Wife</b> Address <b>Catherine S. Henley, (same as #1.)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cor Pulmonale</b> <b>163X</b> DUE TO <b>Radiation Pneumonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <b>Carcinoma of Lung</b> (c) <b>Ischemic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ischemic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>6 wks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> to <b>3-24</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>3-23</b> 19 <b>66</b> , and that death occurred at <b>1:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Andrew G. Prandoni</b>		22b. DATE <b>March 24, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew G. Prandoni, M.D.</b>		22d. ADDRESS <b>2520 L Street, N.W., Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 26, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery,</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Don. De...</b>		25a. REC'D BY REGISTRAR <b>MAR 29 1966</b>	
ADDRESS <b>2224 Wis. Ave N.W. Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03970

03960

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>16 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>FAIRFAX</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairfax, Virginia</b> d. STREET ADDRESS <b>9212 Ponce Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sharilyn (M) HESELTON</b>		4. DATE OF DEATH Month Day Year <b>March 12 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 MAY 1949</b>
9. AGE (In years last birthday) <b>16</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>COCO SOLO, CANAL ZONE</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Leslie R. Heselton</b>	
14. MOTHER'S MAIDEN NAME <b>Jane Tompkins</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>231-68-9649</b>		17. INFORMANT <b>Leslie R. Heselton</b> Address <b>9212 Ponce Place</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rhabdomyosarcoma, Metastatic primary site</b> DUE TO (b) <b>1760</b> DUE TO (c) <b>Bartholin's Gland</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>24 Feb</b> , 19 <b>66</b> , to <b>13 Mar</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12 Mar</b> , 19 <b>66</b> , and that death occurred at <b>6:33 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Kelvin F. Kesler</b>		22b. DATE SIGNED <b>13 Mar 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Kelvin F. Kesler LCDR MC USN</b>		22d. ADDRESS <b>USNH, BETHESDA, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 16, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Arlington Va.</b>
24. FUNERAL DIRECTOR <b>Every Funeral Home</b>		25a. REC'D BY REGISTRAR <b>AR 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03971 CERTIFICATE OF DEATH 03961											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>			c. LENGTH OF STAY IN 1b <u>9 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> 15-1						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4114 DENFELD AVENUE</u>					d. STREET ADDRESS <u>4114 DENFELD AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>FOREST W. HEVENER, JR.</u>			First Middle Last		4. DATE OF DEATH Month <u>MARCH</u> Day <u>7</u> Year <u>1966</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 2, 1922</u> 44 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAB DRIVER &amp; OWNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TAXI</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>STEELE HEVENER</u>					14. MOTHER'S MAIDEN NAME <u>ELLA IRENE MACKAWEE</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>U.S.A.</u>			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>VIRGINIA L. HEVENER - 4114 DENFELD AVE</u>		Address <u>KENSINGTON MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/66</u> , 19 <u>66</u> to <u>3/7/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/5/66</u> 19 <u>66</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Patrick Jameson</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/7/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>PATRICK JAMESON</u>					22d. ADDRESS <u>11718 George Silver Spring, Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>3/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON, VIRGINIA</u>				
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC, SILVER SPRING, MD</u>					ADDRESS		25a. REC'D BY REGISTRAR <u>MAR 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03972

### CERTIFICATE OF DEATH

03962

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NURSING HOME</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BURTONSVILLE</u> 15-1 d. STREET ADDRESS <u>14401 COLUMBIA RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>FRANCES</u> First <u>K</u> Middle <u>HILD</u> Last <b>4. DATE OF DEATH</b> <u>3</u> - <u>11</u> 19 <u>66</u>		<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>8-13-1888</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>77</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Meat Bus.</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Slaughtering</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>HUNGARY</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>13. FATHER'S NAME</b> <u>Philip Brechtwieser</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Dickensheid</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Robert P. Hild, McLean, Va</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>8/1</u> , 19 <u>63</u> , to <u>3/11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/1/66</u> 19 <u>66</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Robert S. McCeney, M.D.</u> <b>22b. DATE SIGNED</b> <u>3/11/66</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>ROBERT S. MCCENEY, M.D.</u> <b>22d. ADDRESS</b> <u>402 Main Street, Laurel, Md</u>				<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>March 14, 1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Union Cemetery</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>Burtonsville Md</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Charles Judge</u> <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				<b>25c. ADDRESS</b> <u>254 Carroll St NW</u> <b>DATE</b> <u>MAR 14 1966</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1880

1880

*[Faint, mostly illegible handwriting throughout the page, possibly representing a ledger or account book.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03973

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 13, 14 Film G376 4/26/66 mh

CERTIFICATE OF DEATH

03963

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEY CHASE</u>		c. LENGTH OF STAY IN 1b <u>4 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8700 JONES MILL RD. CHEY CHASE</u> <u>DETHMA SILVER SPRING NURSING HOME</u>				d. STREET ADDRESS <u>709 CARTER ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>(Hill) AMELIA C Hill</u>				4. DATE OF DEATH Month Day Year <u>MARCH 19 1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUC.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 24 1885</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Prince Edward Is. CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
13. FATHER'S NAME <u>Donald Corbett</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>ROBERT HENDERSON HILL (SON) - SEE ITEM #2 - ABOVE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>4 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV.</u> , 19 <u>65</u> , to <u>3/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/12</u> , 19 <u>66</u> , and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. G. LEONARD GOLD</u>				22d. ADDRESS <u>8641 COLESVILLE ROAD, SILVER SPR. MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-22-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>MAR 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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RECEIVED 10/10/61

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1

M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03974

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03964

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOYDS</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FLORA</u> Middle <u>E.</u> Last <u>HITT</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> , Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/1882</u>
9. AGE (In years last birthday) yrs. <u>83</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>G. ROBERT ELKINS</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE PICKRELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>EDWARD K. PICKRELL JR.</u>		Address <u>GRANDSON</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> <u>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/11/66</u>	
22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/14/65</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		23d. LOCATION (City or Town) (County) (State) <u>Beallsville Maryland</u>	
24. FUNERAL DIRECTOR <u>William B. Hallen, Barnesville, Md</u>		25a. REC'D BY REGISTRAR <u>MAR 16 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Greenville</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>76 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenville</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>						d. STREET ADDRESS <b>124 Augusta Court</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Martin</b>			First <b>Ezelle</b>			Last <b>Holder</b>			4. DATE OF DEATH <b>March 29</b>		Day <b>19</b> Year <b>66</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 August 1900</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Consultant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William H. Holder</b>						14. MOTHER'S MAIDEN NAME <b>Nannie Willis</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric ulcer, perforated</b> <b>1341</b> DUE TO (b) <b>Empyema, pneumothorax, renal failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>Cryptococcal meningitis</b>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from <b>12 January, 1966</b> , to <b>29 March, 1966</b> , that (we) last saw the deceased alive on <b>29 March, 1966</b> , and that death occurred at <b>7:50 AM</b> , from the causes and on the date stated above.												
22a. SIGNATURE <b>Darryl D. Bindschadler</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3/29/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Darryl D. Bindschadler, M.D.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>			23b. DATE THEREOF <b>3/30/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Mem. Park</b>			23d. LOCATION (City, town or county) (State) <b>Greenville, S.C.</b>				
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Md.</b>						25a. REC'D BY REGISTRAR <b>APR 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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Annals of the

William A. Holbert

The Medical Center

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Barry A. Stanchfield, M.D., President of Health, National

The Clinical Center, National

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03976

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03966

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10401 Grosvenor Place</b>		d. STREET ADDRESS <b>10401 Grosvenor Place</b>	
3. NAME OF DECEASED (Type or print) <b>HARVEY H. HOLLAND</b>		4. DATE OF DEATH <b>Mar. 11, 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 26, 1892</b>
9a. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Air Force</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>James T. Holland</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Hodges</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I &amp; II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wife</b>		Address <b>Helen P. Holland Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute -</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio Vascular Disease -</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden -</b> <b>years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 3-11-66 22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-15-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Maryland</b>	
25a. REC'D. BY REGISTRAR <b>MAR 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED  
JAN 20 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY FOR  
GENERAL AFFAIRS  
SIR:  
I have the honor to acknowledge the receipt of your letter of January 16, 1964, regarding the matter of the proposed amendment to the Organic Act of the Virgin Islands. The Department is currently reviewing the proposed amendment and will advise you of the results of its review as soon as possible.

Very truly yours,  
[Signature]  
[Title]

Enclosed for you are two copies of the proposed amendment to the Organic Act of the Virgin Islands, as submitted to the Department by the Virgin Islands Government. One copy is also being furnished to the Department of the Interior, Bureau of Land Management, for its review.

Very truly yours,  
[Signature]  
[Title]

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03977

## CERTIFICATE OF DEATH

03967

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>4304 Rosedale Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Housewife</u> Last <u>Housewife</u>		4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/06</u>
9. AGE (In years last birthday) <u>57</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u></u>	
13. FATHER'S NAME <u>Henry Sanders</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Hayner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Daughter - JOANNE Danelz</u>		18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac response</u> <u>451X</u> DUE TO (b) <u>Dissecting Aneurysm Aorta</u> DUE TO (c) <u>Arterio sclerosis generalized</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-24</u> , 19 <u>56</u> , to <u>3-10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-10-1966</u> , and that death occurred at <u>8:34</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>C. Roger Kuntz, M.D.</u>		22b. DATE SIGNED <u>3-10-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. Roger Kuntz, M.D.</u>		22d. ADDRESS <u>3701 Connecticut Avenue, N.W., Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>AR 14 1956</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03978

## CERTIFICATE OF DEATH

03968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>56 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>5818 Winston St., S. E.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Felix</b> Middle <b>Marvin</b> Last <b>HOWARD</b>		4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 28, 1915</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>50</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Campobello, So. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Green R. Howard</b>		14. MOTHER'S MAIDEN NAME <b>Connie Ballew</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>578-22-7110</b>	
17. INFORMANT <b>S. E., Washington, D. C.</b>		Mrs. Gertrude L. Howard, 5818 Winston St./	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1</b> , 19 <b>66</b> , to <b>Mar. 29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Mar. 29</b> , 19 <b>66</b> , and that death occurred at <b>1008 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. E. Zimmerman</b>		22b. DATE SIGNED <b>Mar. 30, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. E. Zimmerman, M. D.</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-1-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>APR 4 1966</b>	
ADDRESS <b>4th and Massachusetts Ave., N.E. Washington, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

Cleared by Dep. Med. Examiner  
D. J. Reap.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03969

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>2813-University Blvd. West</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Russell</u>		First <u>Porter</u>		Last <u>Howes</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 8, 1904</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rockville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry G. Howes</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Butt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-12-7519</u>		17. INFORMANT <u>Neva Virginia Howes Kensington</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarct</u> <u>4201</u> DUE TO (b) <u>A SHD tanginal syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>23 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan, 1965</u> to <u>3-9, 1966</u> , that (I) (we) last saw the deceased alive on <u>2-28-1966</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>D. J. Sengstack m.d.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>George J. Sengstack</u>				22d. ADDRESS <u>9241 Columbia Ave., S. S., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George's Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>MAR 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Handwritten notes and stamps at the bottom of the page, including a circular stamp on the left and a rectangular stamp on the right.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film G375 4/14/66 mh

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT. C

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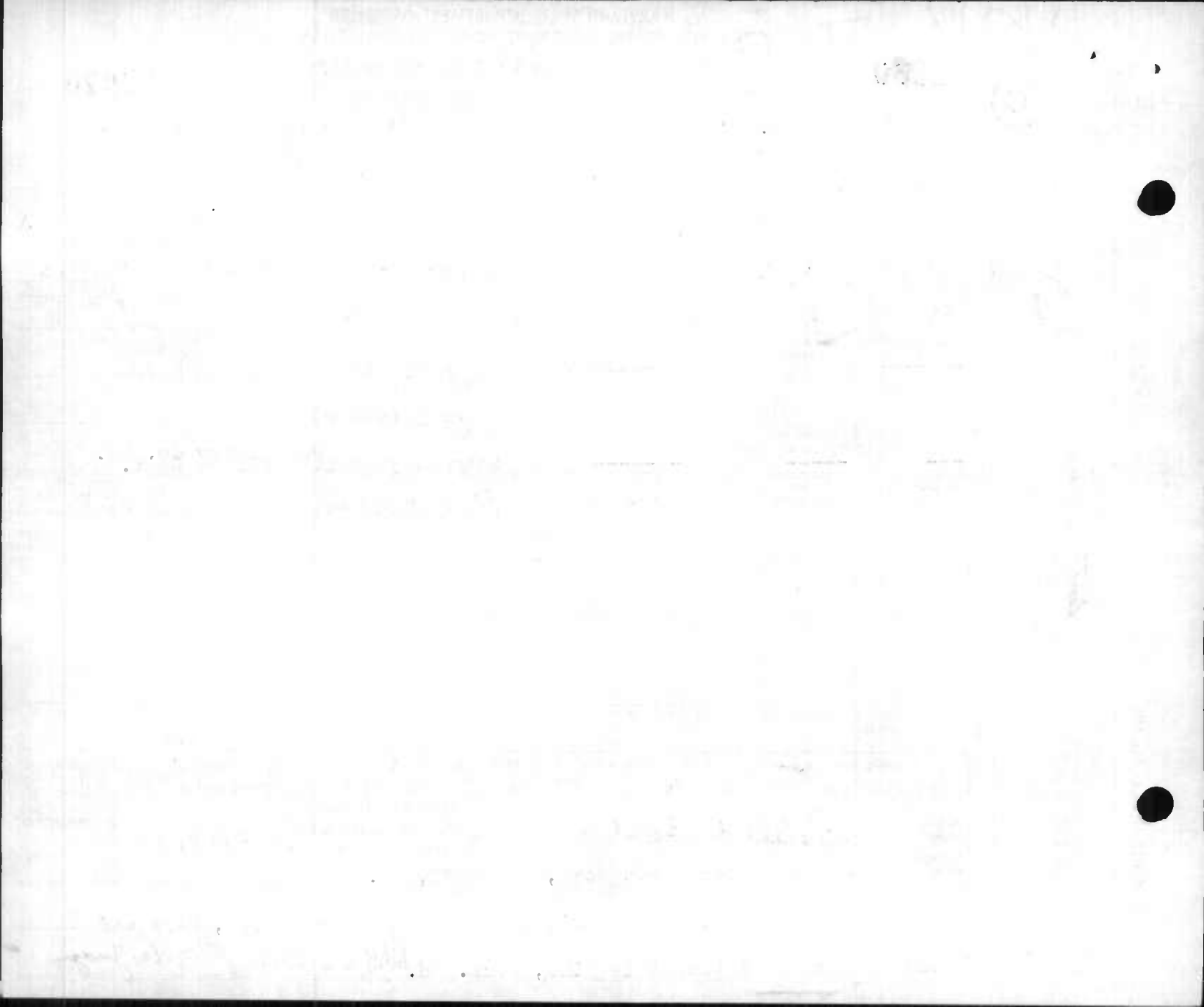
03970

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Birth filed under Campbell

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>2 Mon.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		<u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>608 Longwood Dr.</u>				d. STREET ADDRESS <u>608 Longwood Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Twin II</u> Middle <u>Hubbard</u> Last				4. DATE OF DEATH <u>March 18</u> 19 <u>66</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1966</u>	9. AGE (In years lost birthday) yrs. <u>24</u>	IF UNDER 1 YEAR Months <u>24</u>	IF UNDER 24 HRS. Hours <u>24</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Caren Hubbard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u> ((If yes give war or dates of service))		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Montgomery County Welfare Dept.</u> Address <u>Montgomery Co. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7630</u> <u>Bronchial Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u>		EXAMINER'S NAME (Type) <u>7936 Old Georgetown Road, Bethesda, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>3/18/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler 1331 Rockville Pike, Rock. Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03982												03971	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George's</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>3 HRS. 25 MIN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ADELPHI 16-2</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASH. SAN. &amp; HOSPITAL</b>						d. STREET ADDRESS <b>1826 METZEROTT RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ISRAEL</b> First <b>IRVING</b> Middle <b>HUBSHMAN</b> Last			4. DATE OF DEATH <b>MARCH 12</b> Month <b>19 66</b> Day Year										
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-21-65</b>		9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PENNA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Emil HUBSHMAN</b>						14. MOTHER'S MAIDEN NAME <b>Lustig</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>CHART (Hospital Records)</b> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive, Cardiovascular Disease</b> DUE TO (c) <b>Arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>10 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive Arteriosclerosis Cardiovascular Disease</b>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>6-</b> , <b>1964</b> , to <b>3-12</b> , <b>1966</b> , that (I) (we) last saw the deceased alive on <b>3-12</b> <b>19 66</b> , and that death occurred at <b>10:25</b> M., from the causes and on the date stated above.													
22a. SIGNATURE <b>Morton Aitschuler</b>						22b. DATE SIGNED <b>3-12-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Morton Aitschuler</b>					
22d. ADDRESS <b>9205-New Hang Ave. - Silver Spring, Md.</b>						22e. REC'D BY REGISTRAR <b>Charles Judge</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colman Manor Md</b>					
24. FUNERAL DIRECTOR <b>Francis Pasch's Sons Hyattsville, Md</b>						25a. REC'D BY REGISTRAR <b>MAR 15 1966</b>							
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>													

823

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03982					03972				
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>93 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Culpeper</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Culpeper</b> d. STREET ADDRESS <b>406 Macoy Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Laura Louise Hurt</b>			4. DATE OF DEATH <b>March 30 1966</b>			5. AGE (In years last birthday) <b>10 yrs.</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>14 April 1955</b>		9. IF UNOER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Werter H. Hurt, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Susan Dickinson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record, The Clinical Center, Bethesda, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute multifocal hemorrhagic pneumonia</b> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphocytic leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Abscesses of liver, spleen and kidneys.</b> <b>Rectal ulcer with abscess.</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that <b>MD</b> (this hospital) attended the deceased from <b>27 December 1965</b> , to <b>30 March, 1966</b> that <b>XX</b> (we) last saw the deceased alive on <b>March 30 1966</b> , and that death occurred at <b>1100 AM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Robert C. Gallo</b> 22b. DATE SIGNED <b>30 March 1966</b> 22c. PHYSICIAN'S NAME (Type) <b>Robert C. Gallo, M.D.</b> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>April 2, 1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Stevensburg Baptist</b> 23d. LOCATION (City, town or county) (State) <b>Stevensburg, Virginia</b> 24. FUNERAL DIRECTOR <b>Clore Funeral Home, Culpeper, Va.</b> 25a. REC'D BY REGISTRAR <b>APR 4 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

03937

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CHICAGO

VIRGINIA

INDICATED

CHICAGO

33 DAYS

SECURITY

100 N. W. Avenue

The Clinical Center, Bethesda, Maryland

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U.S.A.

VIRGINIA

NOT EMPLOYED

SECURITY

STAN BISHOP

STAN BISHOP, JR.

The Medical Record

The Clinical Center, Bethesda, Maryland

NAME

NO

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/10/00 BY 1043

1043

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/10/00 BY 1043

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/00 BY 1043

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03983

03973

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN IB <u>1 Yr. 7 Das.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				d. STREET ADDRESS <u>1300 U St., S. E. Apt. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Victoria</u> Middle <u>Brunk</u> Last <u>HUTCHESON</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>19 66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 18, 1894</u>		
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Manchester, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Belle Brunk</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Kentland, Md.</u> <u>Mr. Fred Hutcheson, 1734 Kilmer St., /</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>452x</u> IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Aneurysm Right Posterior Cerebral Artery</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>53 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (t) (this hospital) attended the deceased from <u>Mar. 9</u> , 19 <u>65</u> , to <u>Mar. 17</u> , 19 <u>66</u> that (t) (we) last saw the deceased alive on <u>Mar. 17</u> 19 <u>66</u> , and that death occurred at <u>800A</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>W. L. Brannon</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Mar. 18, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>W. L. Brannon, M. D.</u>				22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-21-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>		
24. FUNERAL DIRECTOR <u>Canale Windsor Demaine Funeral Home</u> <u>520 South Washington St., Alexandria, Va.</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1950

CENTRAL OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03984											
03974											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville 16-2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014						d. STREET ADDRESS 81071 Darcy Road					
3. NAME OF DECEASED (Type or print) Ralph Theodore Hutchison			First Middle Last			4. DATE OF DEATH March 9 19 66			Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 January 1911 55 yrs.		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (General)				10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard Hutchison						14. MOTHER'S MAIDEN NAME Minnie Simpson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579-10-0444		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Herniation of intracranial contents secondary to/ 355X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Status post right parietal craniotomy DUE TO (c) Right parietal glial tumor of the brain PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 23, 1966, to March 9, 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 9 1966, and that death occurred at 6:04 P.M. from the causes and on the date stated above. 22a. SIGNATURE John M. Van Buren M.D. 22b. DATE SIGNED March 9 1966 22c. PHYSICIAN'S NAME (Type) John Van Buren, M.D. 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/12/66 23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery 23d. LOCATION (City, town or county) (State) Forestville Md. 24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md. 25a. REC'D BY REGISTRAR DATE MAR 15 1966 25b. REGISTRAR'S SIGNATURE Charles Judge											



4# 1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03985 CERTIFICATE OF DEATH 03975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>9 Hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u> d. STREET ADDRESS <u>9131 Bradford Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Burdette</u> Middle <u>Hyde</u> Last		4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/4/87</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery Schools</u>		11. BIRTHPLACE (County & State, or foreign country) <u>IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>James Hyde</u>		
14. MOTHER'S MAIDEN NAME <u>Hannah Brownfield</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		
16. SOCIAL SECURITY NO. <u>214-03-8553</u>			17. INFORMANT <u>Sadie M. Hyde</u> Address <u>9131 Bradford Rd., S. S., Md.</u> <u>Hospital Records</u> <u>Takoma Park Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 4200 DUE TO (b) <u>Chronic Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Generalized Arteriosclerosis</u> 10 yrs.					INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>40</u> , to <u>3-19</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>3-19</u> 19 <u>66</u> and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>N. C. Shoemaker M.D.</u>			22b. DATE SIGNED <u>3-19-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>N. C. Shoemaker, M.D.</u>			22d. ADDRESS <u>811 Dale Dr. Silver Spring, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 22, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Prince George's Co., Md.</u>		25a. REC'D BY REGISTRAR <u>8434 Georgia Avenue</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 24 1966</u>	

MEDICAL CERTIFICATION

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MAR 2 1958

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03986

## CERTIFICATE OF DEATH

03976

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN <u>5 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>10910 Seven Lakes Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Hester</u> Middle <u>S</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/3/1875</u>		9. AGE (In years lost birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland (Mont. Co)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Carter</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Jenkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>daughter Rebecca Palmer</u> Address <u>Bethesda Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>10:05</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Pollen</u>				22b. DATE SIGNED <u>3/18/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>				22d. ADDRESS <u>10511 SUMMIT AVE, KENSINGTON MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/22/66</u>		23c. NAME OF CEMETERY OR CRAMATORY <u>Lincoln Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>George R. Snowden</u> ADDRESS <u>Rockville Md</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 23 1966</u>		25b. REGISTRAR'S SIGNATURE	

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88230



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03987

## CERTIFICATE OF DEATH

03977

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>13 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laytonsville</u> <u>15-1</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Sarah E. Jackson</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 2 19 66</u>					
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>Cal</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4/17/06</u>		<b>9. AGE</b> (In years last birthday) yrs. <u>59</u> <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William Jackson</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic valvular heart disease</u> <u>414X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10</u> years	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u>, 19<u>66</u> to <u>3/2</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>3/2</u> 19<u>66</u>, and that death occurred at <u>9:30</u> M, from causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>William H. Hilly</u>						<b>22b. DATE SIGNED</b> <u>3-3-66</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type)						<b>22d. ADDRESS</b>			
<b>23a. BURIAL CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>3/5/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Brooke Grove</u>		<b>23d. LOCATION</b> (City or Town) (County) (State) <u>Laytonsville Montg Md.</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Robert L. Snowden Rockville Md.</u>						<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 7 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

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RECORDS OF THE

1953

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03988

03978

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San't Hospital</i>		d. STREET ADDRESS <i>7221 Spruce Ave</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>John H. Jones</i>		4. DATE OF DEATH Month Day Year <i>3 18 1966</i>	
5. SEX <i>male</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) yrs. <i>63</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Body Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>	11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>
13. FATHER'S NAME <i>James P. Jones</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Beal</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes</i>		16. SOCIAL SECURITY NO. <i>248-05-5433</i>	
17. INFORMANT <i>Mrs. Madeline O. Jones (Same as #2)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1561 Pulmonary Embolism - Recent -</i> DUE TO (b) <i>Carcinoma of Liver with Metastasis</i> DUE TO (c) <i>6 Mo.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. ACTUAL SIGNATURE <i>John G. Ball</i> EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		22. DATE SIGNED <i>3/18/66</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>Mar. 21, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery Prince Geo. Co. Md.</i>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Arthur H. Hutton, 257 Carroll St N/W LFC</i>		25a. BY REGISTRAR <i>MAR 21 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03979

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>6 ddays</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM</u>				d. STREET ADDRESS <u>11801 RENICK LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LUCILLE BARNES JONES</u>			4. DATE OF DEATH <u>March 5 1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 22, 1897</u> 68 yrs.	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housemother</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>WILLIAM JONES</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE BARNES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214 16 6269</u>		17. INFORMANT <u>Anne Jones Waller</u> Address <u>11801 Renick Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 days</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> , 19 <u>66</u> , to <u>3/5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/5</u> 19 <u>66</u> , and that death occurred at <u>9:55</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Norman H. Richardson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman H. Richardson</u>				22d. ADDRESS <u>10480 N. H. Ave. Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>McMahon Presbyterian</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill, Md.</u>	
24. FUNERAL DIRECTOR <u>Norman F. Gorman</u>				ADDRESS <u>Snow Hill, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 9 1966</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03990

03980

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>13 Hours</u>				d. STREET ADDRESS <u>2609 Elmore Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Germanas Karch</u>				4. DATE OF DEATH <u>March 3 1966</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1895 September 7 1895</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Interior Department</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Karch</u>				14. MOTHER'S MAIDEN NAME <u>Mary Luben</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 1 217-44-0478</u>		17. INFIRMANT <u>Mrs. Evelyn B. Karch</u> Address <u>2609 Elmore St. S.S., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute Myocardial Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>January, 1959</u> to <u>3/3/1966</u> , that (I) <u>(the hospital)</u> last saw the deceased alive on <u>3/3/1966</u> and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Selden R. Reap</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>MAR. 3, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>SELDEN R. REAP, M.D.</u>				22d. ADDRESS <u>Wheaton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 7, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

103280

103280

Montgomery  
Silver Spring  
Holy Cross Hospital

Montgomery  
Silver Spring  
2103 E. Main Street

Male white  
James G. X  
September 1947 to  
March 2

Retired - Interior Department  
Maryland  
U.S.A.

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03991 CERTIFICATE OF DEATH 03981

1. PLACE OF DEATH a. COUNTY <u>MONT GOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1401 Bel Air Mill Rd 15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>KASSAN</u> Last <u></u>		4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Eliyahu Frank</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u>CORONARY ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>64</u> , to <u>3-6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-5</u> , 19 <u>66</u> , and that death occurred at <u>11:55</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard H. Ostrow</u> M.D.		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD H. OSTROW</u>		22d. ADDRESS <u>8107 EASTERN AVE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>3/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>B. W. [unclear] &amp; Sons - 3501 14th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 9 1966</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Congressional Manor</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>9222 Shelton Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>PAULINE M. KATROSH</b>			First Middle Last		4. DATE OF DEATH <b>March 14, 19 66</b>		Month Day Year				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 7, 1897</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR <b>8</b> Months <b>7</b> Days IF UNDER 24 HRS. <b>15</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Michael Kurrila</b>					14. MOTHER'S MAIDEN NAME <b>Anna (Unknown)</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Husband</b> <b>Ralph A. Katrosh</b>		Address <b>Same as Item 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>331X</b> DUE TO <b>HYPOSTATIC PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>CEREBRO-VASCULAR ACCIDENT</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>RECENT SUBDURAL HEMATOMA (DEC. '65)</b>										INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTES</b> <b>5 DAYS</b> <b>3 WEEKS</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 23, 1965</b> , to <b>March 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 12, 1966</b> , and that death occurred at <b>6:20 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Joseph D. Connor</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>15-MARCH 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH D. CONNOR</b>						22d. ADDRESS <b>Bethesda, 9420 Old Georgetown Rd. Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
<b>Burial-transit 3-15-66</b>		<b>St. Stephens Cemetery</b>		<b>Lehman, Penna.</b>							
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>						ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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STATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																													
CERTIFICATE OF DEATH																													
03998		Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100						03998																					
1. PLACE OF DEATH COUNTY <b>MONTGOMERY</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY																							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>						c. LENGTH OF STAY IN 1b <b>1 DAY</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C. 47-3</b>																	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital</b>						d. STREET ADDRESS <b>849 OGLETHORPE ST</b>						6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <b>DAVID NATHANIEL KING</b>						4. DATE OF DEATH Month <b>MARCH</b> Day <b>15</b> Year <b>1966</b>																							
5. SEX <b>M</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-9-07</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>LOAN Co.</b>						11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>David N. King</b>						14. MOTHER'S MAIDEN NAME <b>Estelle Dixon</b>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT <b>MAE KING</b> Address <b>849 OGLETHORPE STREET N.E.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage right cerebral hemisphere</b> DUE TO <b>hemisphere</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Myocardial hypertrophy</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																	
21. I certify that (I) (this hospital) attended the deceased from <b>3/14/66</b> , 19__, to <b>3/15/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>3/15/66</b> , 19__, and that death occurred at <b>7:25 PM</b> , from the causes and on the date stated above.																													
22a. SIGNATURE <b>Henry C. Scruggs</b>												M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>3/16/66</b>													
22c. PHYSICIAN'S NAME (Type) <b>Henry C. Scruggs, M.D.</b>												22d. ADDRESS <b>Georgetown Doctors' Park 5413 Cedar Lane, Bethesda, Md.</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				23b. DATE THEREOF <b>3/19/1966</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Ship to</b>				23d. LOCATION (City, town or county) (State) <b>Norfolk, Virginia</b>																	
24. FUNERAL DIRECTOR <b>W. Ernest Jarvis Co., Inc. 1432 You St., N.W.</b>												25a. REC'D BY REGISTRAR <b>Charles Judge</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>													

1903

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International Association of Agricultural Chemists

Headquarters

Monetary and Agricultural

George W. Bostwick, Jr.  
215 Cedar Lane, Richmond, Va.

Henry C. Schuyler, Jr.

Richmond, Virginia

Richmond

Richmond, Virginia

Richmond, Virginia

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03994

03984

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>4806 Eades St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Nannie Myrtle King</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 24 19 66</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1/26/1893</u>		<b>9. AGE</b> (In years last birthday) yrs. <u>73</u> IF UNDER 1 YEAR Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret. Accounting clerk</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U. S. Govt.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cheloland, Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Thomas</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ida Counts</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> (If yes give war or dates of service) <u>None</u>		<b>17. INFORMANT</b> <u>Joanna Price</u> <u>4806 Eades Street</u> <u>Rockville, Maryland</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Carcinoma, metastatic, lungs</u> DUE TO (c) <u>Carcinoma, Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Mar. 10, 19 66</u> , to <u>Mar. 24, 19 66</u> that (I) (we) last saw the deceased alive on <u>Mar. 23, 19 66</u> , and that death occurred at <u>11:05 PM</u> , from causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>Philip H. Varner</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3/24/66</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Philip H. Varner</u>				<b>22d. ADDRESS</b> <u>10620 Georgia Ave., Wheaton, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>26 March 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery</u>		<b>23d. LOCATION</b> (City or Town) (County) (State) <u>Prince George Co., Maryland</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Warner E. Pumphrey, Inc.</u> <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 28 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

• 2000 •

## CERTIFICATE OF DEATH

Reg. Dist. No. 03985

03995

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>16 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10400 Amherst Street</u>				d. STREET ADDRESS <u>10400 Amherst ST</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Kourpias</u>				4. DATE OF DEATH Month Day Year <u>March 31 1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28, 1901</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u> ✓	
13. FATHER'S NAME <u>George Kourpias</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>George Kourpias</u> Address <u>10400 Amherst Avenue Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis - etiology unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/29</u> , 19 <u>66</u> , to <u>3/31</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>66</u> , and that death occurred at <u>6:39</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond T. Benack</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>4115 Colie Drive Wheaton MD 3/31/66</u>			
PHYSICIAN'S NAME (Type) <u>Raymond T. BENACK MD</u>				ADDRESS <u>4115 Colie Drive, S. S., Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4 April 1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grace Land Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sioux City, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				24a. REC'D BY REGISTRAR <u>APR 5 1966</u>		24b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03996 CERTIFICATE OF DEATH 03986										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Maryland</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>SILVER SPRING</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>2445 Littons ville Rd. S.S. Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>Eugene</u> Last <u>Krackow</u>					4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/7/14</u>		9. AGE (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>toxicologist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, N.Y.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris KRACKOW</u>					14. MOTHER'S MAIDEN NAME <u>Ann Seligman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>MRS. AUDREY RUTH KRACKOW</u> Address <u>2445 LITTONSVILLE RD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial infarction</u> DUE TO (c) <u>Coronary artery disease</u> <u>4-5 years</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3-10</u> , 19 <u>66</u> , to <u>3-14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-10</u> , 19 <u>66</u> , and that death occurred at <u>10:15 AM</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Herbert L. Tanenbaum</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>3-17-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>HERBERT L. TANENBAUM</u>					22d. ADDRESS <u>4400 Conn Ave. NW WASH DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>3/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHIZUK AMUNO (ARLINGTON)</u>			23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>		
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>					25a. REC'D BY REGISTRAR <u>MAR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Closed by Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
03997 03987													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>10 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>748 Thayer Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harriet J. Krajewski</u>			First Middle Last			4. DATE OF DEATH <u>March 23 1966</u>			Day Year				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 30 1882</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Tracked</u>						14. MOTHER'S MAIDEN NAME <u>Julia Smith</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-48-6882</u>		17. INFORMANT <u>Stanley Krajewski</u>		Address <u>748 Thayer Avenue Silver Spring, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary artery insufficiency</u> DUE TO (b) <u>Hypertensive cardiovascular Heart Disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene left leg -</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Known 6 weeks</u> <u>Known since 1952</u> <u>Unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 14</u> , 1952, to <u>March 23</u> , 1966, that (I) (we) last saw the deceased alive on <u>March 22</u> 1966, and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Aaron H. Traum</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 23, 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>						22d. ADDRESS <u>8237 Georgia Ave - Silver Spring, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>March 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>MAR 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

7025

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03988

1. PLACE OF DEATH a. COUNTY <i>Montg</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Montg</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillendale</i>		c. LENGTH OF STAY IN 1b <i>3 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary J. Freamer</i>		4. DATE OF DEATH Month <i>3</i> - Day <i>24</i> Year <i>1966</i>	
5. SEX <i>fm</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-5-1902</i>
9. AGE (In years lost birthday) <i>63 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>L. R. M.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>L. B. M.</i>	
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Freamer</i>		14. MOTHER'S MAIDEN NAME <i>Shoemaker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>554</i>	
17. INFORMANT <i>Freamer</i> Address <i>2008 Forest Hill Dr.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Symphoviremia</i> 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1956</i> , 19, to <i>3/24</i> , 19 <i>66</i> that I last saw the deceased alive on <i>3-23</i> , 19 <i>66</i> , and that death occurred at <i>109 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James J. Burns</i> M.D.		DATE SIGNED <i>1835 E 8th N.W. 3/24/66</i>	
PHYSICIAN'S NAME (Type) <i>JAMES T. BURNS M.D.</i>		<i>D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/28/66</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Pn Geo Co Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. R. Huntemann &amp; Son Funeral Home</i>		24a. REC'D BY REGISTRAR <i>Charles Judge</i> 24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03989

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>5 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		d. STREET ADDRESS <u>4510 Woodfield Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>A.</u> Last <u>KREAMER</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-1894</u>
9. AGE (In years last birthday) yrs. <u>71</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>I.B.M.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Kreamer</u>		14. MOTHER'S MAIDEN NAME <u>Ella Shoemaker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>577-10-0985</u>	
17. INFORMANT <u>Brother in Law Robert E. Fennelly</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>ARTERIO SCLEROTIC HEART DS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2</u> <u>2+ WEEKS</u> <u>10+ YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>POSSIBLE MALIGNANCY UREMIA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>D. N. A.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/3, 1958</u> , to <u>3/8, 1966</u> , that (I) (we) last saw the deceased alive on <u>3/7, 1966</u> , and that death occurred at <u>7:15 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles J. Savarese, M.D.</u>		22b. DATE SIGNED <u>3/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, M.D.</u>		22d. ADDRESS <u>1125 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11 MARCH, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT. CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VA.</u>	
24. FUNERAL DIRECTOR <u>Robert A. DeVoe</u>		25a. REC'D BY REGISTRAR <u>Home Wash D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 14 1966</u>	

4220



4220



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

**04000**

**03990**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN TB <b>50 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47-3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>8 Keel Green, S. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Wilburn</b> Middle <b>Russell</b> Last <b>LANGLEY</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 17, 1931</b>		9. AGE (In years last birthday) <b>35</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Nashville, Tenn</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter A. Langley</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Mayline Magee</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>411 42 0680</b>		17. INFORMANT Address <b>Washington, D.C.</b> <b>Mrs. Joyce M. Langley 8 Keel Green S.W.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Polyarteritis Nodosa</b> <b>456X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Feb. 2</b> , 19 <b>66</b> , to <b>Mar. 24</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>Mar. 24</b> 19 <b>66</b> , and that death occurred at <b>837P M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>J. E. Zimmerman</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Mar. 25, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. E. Zimmerman, M. D.</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Nashville, Tenn.</b>	
24. FUNERAL DIRECTOR <b>Washington, D. ADDRESS</b> <b>W. W. Chambers Funeral Home, 1400 Chapin St. N.W.</b>				25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05250

STATE OF NEW YORK

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APR 24 1968 10:00 AM

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03991

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> c. LENGTH OF STAY IN lb <u>1 Mon-9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>730 Silver Spring Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Helen K. Larsen</u>		<b>4. DATE OF DEATH</b> <u>March 23 1966</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct., 29, 1879</u>
<b>9. AGE</b> (In years last birthday) <u>86</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>FRANCE</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Charles Gloess</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-03-8607B</u>	
<b>17. INFORMANT</b> <u>Kenneth J. Heinrich</u>		<b>Address</b> <u>13616 Loree Lane Silver Spring, Maryland</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>30 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that</b> <u>(11)</u> (this hospital) attended the deceased from <u>December, 1965</u> , to <u>March 22, 1966</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>March 22, 1966</u> , and that death occurred at <u>2:15</u> M., from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>James R. Coleman MD</u>		<b>22b. DATE SIGNED</b> <u>MAR 23 1966</u>	<b>22c. PHYSICIAN'S NAME (Type)</b> <u>JAMES R. COLEMAN</u>
<b>22d. ADDRESS</b> <u>9241 COLUMBIA BLVD SILVER SPRING, MARYLAND</u>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>25 March 1966</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>George Washington Cemetery</u>	<b>23d. LOCATION (City, town or county) (State)</b> <u>BX Hyattsville, Maryland</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 28 1966</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cormor (An B. Prop MD) notified  
 Approved my signing certificate gpc

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RECEIVED BY DATE

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MAR 28 1968

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Dr. Reap notified - not a coronis case

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>MONTGOMERY</u>		03992	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>1 hr. 45 min</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		15-1		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>3516 PERRY AVENUE</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Otto</u>		First		Middle		Last		4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 2 1904</u>		9. AGE (in years last birthday) <u>61 1/2</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>12</u> IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHEF ENGINEER, Maint. Office Building</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENNSYLVANIA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Braden Leichter</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>193-07-6613</u>		17. INFORMANT <u>Charles Leichter same as #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ DUE TO (b) _____ (c) _____ DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>1/2/66</u> , 19 <u>66</u> , to <u>3/4/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/4/66</u> 19 <u>66</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Patrick Jameson</u>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/4/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Patrick Jameson</u>		22d. ADDRESS <u>11718 Georgia Silver Spring, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		23d. LOCATION (City, town or county) _____ (State) _____			
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>8434 Ga., Ave., S.S., Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

8020

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04003

03993

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MIDDLE			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>			d. STREET ADDRESS <b>6916 Willow Street, N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Wayne</b> Last <b>LEONARD</b>			4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 66</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1965</b>		9. AGE (In years last birthday) yrs. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Chelsea, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Michael W. Leonard</b>			14. MOTHER'S MAIDEN NAME <b>Antionette Scannelli</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Father</b> Address <b>Same as Item 2.</b> <b>Mr. Michael W. Leonard</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>490X</b> IMMEDIATE CAUSE (a) <b>Bilateral pneumonia associated with</b> DUE TO <b>leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from <b>Mar. 12</b> , 19 <b>66</b> , to <b>Mar. 14</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>Mar. 14</b> 19 <b>66</b> , and that death occurred at <b>450P</b> M, from causes on and on the date stated above.					
22a. SIGNATURE <b>Ronald F. Swanger</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Mar. 15, 1966</b>
22c. PHYSICIAN'S NAME (Type) <b>Ronald F. Swanger M. D.</b>			22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-16-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>N. Eagle Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Eagle, Michigan</b>		
24. FUNERAL DIRECTOR <b>R. A. Pumphrey Funeral Home</b>			25a. REC'D BY REGISTRAR <b>MAR 18 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03003

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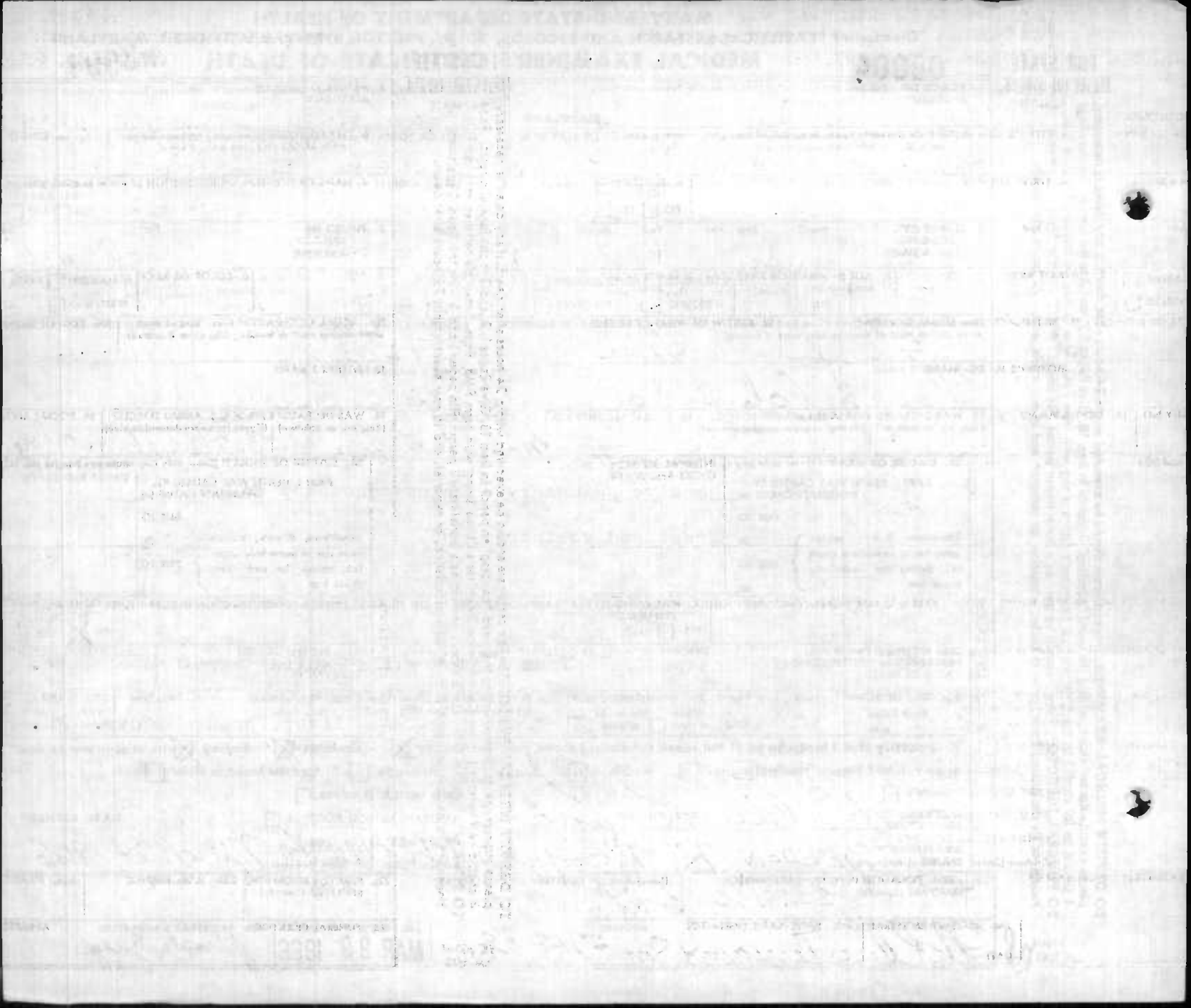
2-1-60

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03994

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS HOSP				d. STREET ADDRESS 2307 WESTVIEW DR.			
3. NAME OF DECEASED (Type or print) First Middle Last MADY M. LERARIO				4. DATE OF DEATH Month Day Year 3 24 1966			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/15/99	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H wife				10b. KIND OF BUSINESS OR INDUSTRY Home			
11. BIRTHPLACE (State or foreign country) ITALY				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Joseph Calaprio				14. MOTHER'S MAIDEN NAME Victoria Lesci			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. [blank]			
17. INFORMANT Mr. Peter Lerario				Address 2307 Westview Dr. SS Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolus secondary to 9010 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) fractured vertebra. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased fell from ladder while hanging curtains at home.			
20c. TIME OF INJURY Hour Minute p.m. 1:30 3/16 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Silver Spring Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED March 24, 1966				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-29-66		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cem	
22d. LOCATION (City, town, or county) (State) Silver Spring Md.							
23. FUNERAL DIRECTOR W. H. Hunterman & Son				ADDRESS 5732 La Ave			
24a. REC'D BY REGISTRAR MAR 29 1966				24b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04005

03995

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>21 years</u>		d. STREET ADDRESS <u>2028 Glen Ross Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2028 Glen Ross Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Wayne</u> Last <u>LeRoy</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2, 1938</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months <u>15</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Market</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Claude A. LeRoy</u>		14. MOTHER'S MAIDEN NAME <u>Florence L. Starr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-36-2637</u>	
17. INFORMANT <u>Claude A. LeRoy</u> <u>Father</u>		Address <u>Silver Spring, Md.</u> <u>2028 Glen Ross Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> <u>9731</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Run. car. into in closed garage.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:00 a.m. 3/19 1966</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>garage</u>	20f. (City or town) (County) (State) <u>Silver Spring Mont. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>3/19/66</u> <u>Bethesda Md.</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar. 22, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cortland Rural Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cortland, Cortland, N. Y.</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAR 24 1966</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04006

03996

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8822 Lanier Drive</b>				d. STREET ADDRESS <b>8822 Lanier Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ESTHER</b> Middle <b>LEVIN</b> Last <b>LEVIN</b>		4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>19 66</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1887</b>		9. AGE (In years lost birthday) yrs. <b>79</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Theodore Schofield</b>				14. MOTHER'S MAIDEN NAME <b>Norma Freedman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Ann Filderman Same as 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x Acute Coronary Thrombosis</b> DUE TO (b) <b>arteriosclerotic Cardio-vascular disease</b> DUE TO (c) <b>diabetes</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>5 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1966</b> to <b>Mar 28</b> , 1966, that (I) (we) last saw the deceased alive on <b>Mar 27</b> , 1966, and the death occurred at <b>3:55 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Simon C. Weiner</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/28/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SIMON C. WEINER M.D.</b>				22d. ADDRESS <b>8201-16 1/2 ST. SILVER SPRING MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-30-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Montefiore Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Montgomery County Pa.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Goldberg Funeral Home 4217 9th St., N.W.</b>				25a. REC'D BY REGISTRAR <b>MAR 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to loan papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04007 CERTIFICATE OF DEATH 03997

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1 d. STREET ADDRESS <u>11431 Lockwood Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>First MYER Middle LEVY Last</u> 4. DATE OF DEATH <u>March 15 19 66</u>			5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>5/17/96</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Jacob Levy</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>W.W. I</u> 16. SOCIAL SECURITY NO. <u>217-30-2414</u> 17. INFORMANT <u>Evelyn Barr, Daughter</u> Address <u>10602 Lester St Sil. Spr., Md.</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 VENTRICULAR FIBRILLATION</u> DUE TO (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>30 MIN</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL, 1965</u> to <u>MAR, 1966</u> that (I) (we) last saw the deceased alive on <u>15 MARCH 19 66</u> , and that death occurred at <u>1045 P</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Walter E. Goozh</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>15 MAR 66</u>			22c. PHYSICIAN'S NAME (Type) <u>Walter E. Goozh</u> 22d. ADDRESS <u>2390 Glenmont Circle Wheaton, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-17-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Nat'l Memorial Park</u> 23d. LOCATION (City, town or county) (State) <u>Falls Church Va.</u>			24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u> ADDRESS <u>4217-9th St. N.W.</u> 25a. REC'D BY REGISTRAR <u>18 MAR 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04008

CERTIFICATE OF DEATH

03998

1. PLACE OF DEATH a. COUNTY <u>CHEVY CHASE MOUNTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE MD</u> c. LENGTH OF STAY IN 1b <u>10 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Maryland</u> d. STREET ADDRESS <u>9114 Jones Mill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JULIUS</u> First <u>LIPOVSKY</u> Middle <u>LIPOVSKY</u> Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-15-1892</u> 9. AGE (In years lost birth) <u>74</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCEER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		4. DATE OF DEATH <u>3-27-1966</u> Month <u>3</u> Day <u>27</u> Year <u>19</u> 13. FATHER'S NAME <u>DANIEL Lipovsky</u> 14. MOTHER'S MAIDEN NAME <u>UNK</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>032 16 8505</u> 17. INFORMANT <u>SON</u> Address <u>9114 JONES MILL RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4221</u> DUE TO <u>ARTERIO-SCLEROTIC CARDIOVASC DTS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF PROSTATE - METASTATIC</u> DUE TO (c) <u>RHEUMATOID ARTHRITIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES - 3 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>3 yrs</u> <u>30 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>63</u> , to <u>Mar</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>3-26</u> 19 <u>66</u> , and that death occurred at <u>10 A</u> .M, from causes and on the date stated above. 22a. SIGNATURE <u>Marvin Fuchs MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>MARVIN FUCHS MD</u> 22d. ADDRESS <u>5315 Connecticut Ave, DC</u> 22b. DATE SIGNED <u>3-27-1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/29/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cemetery</u> 23d. LOCATION (City or Town) (County) (State) <u>Hillside, Maryland</u>		24. FUNERAL DIRECTOR <u>B. Danzansky &amp; Sons 3501 14th St., N. W.</u> 25a. REC'D BY REGISTRAR <u>MAR 31 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03999

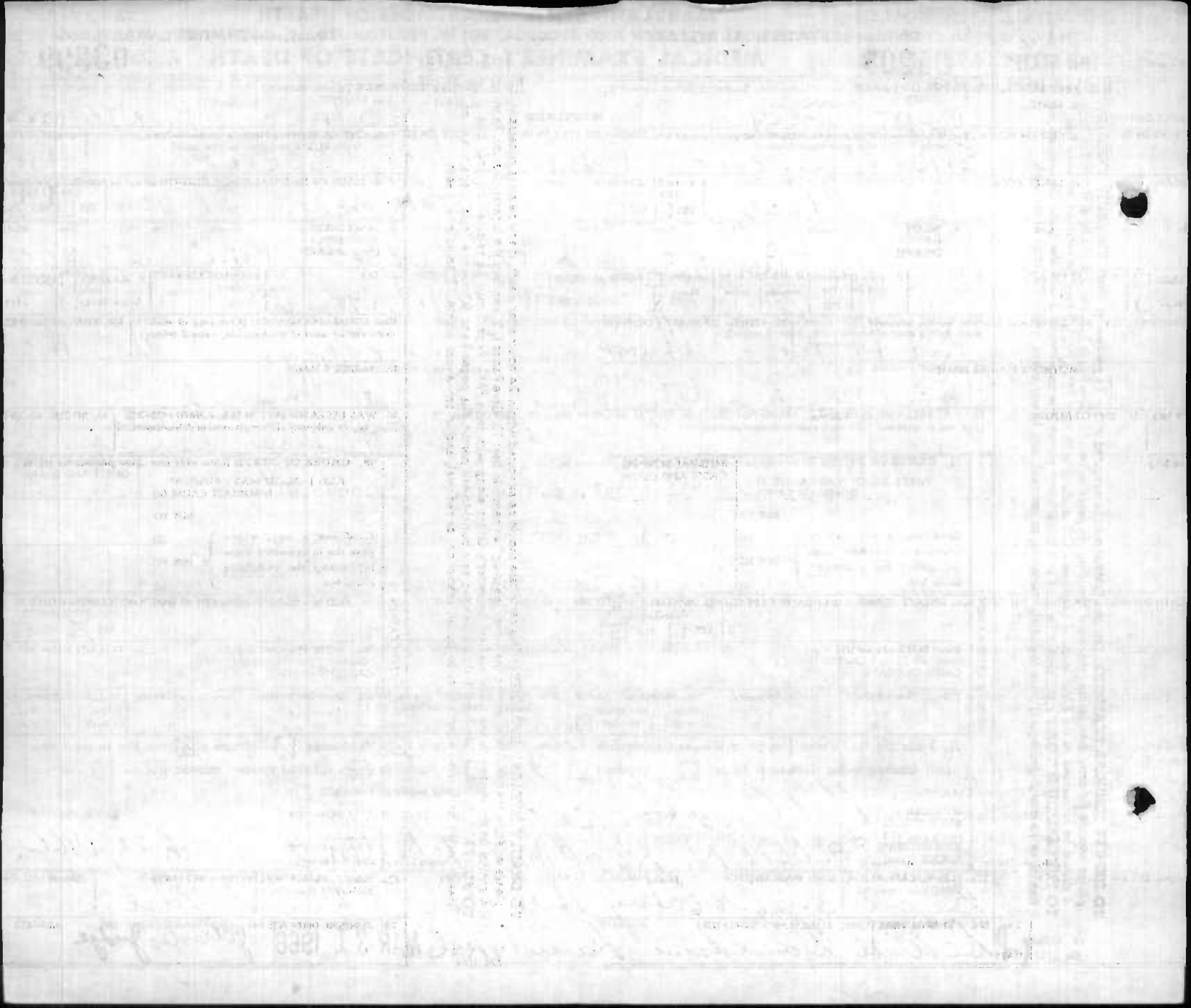
04003

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY in lb <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> f. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>1807 ALBERTI DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>LITZENBURG</b> Last <b>SR.</b>				4. DATE OF DEATH Month <b>MAR.</b> Day <b>22</b> Year <b>1966</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/11/1898</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Walther Litzenburg</b>				14. MOTHER'S MAIDEN NAME <b>Maud Emerick</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Frank Litzenburg</b>			
17. INFORMANT <b>Silver Spring Md</b>				Address <b>1807 Alberti Dr</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral, panlobar, staphylococcal</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>aureus pneumonia.</b> DUE TO (c) <b>Chronic inanition, severe.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> el work Not While <input type="checkbox"/> el work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BELODEN R. REAP M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>March 22, 1966</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3-26-66</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Fry Hill Cem</b>				22d. LOCATION (City, town, or county) (State) <b>Laurel Md.</b>			
23. FUNERAL DIRECTOR <b>De Witt Sanderson</b>				24a. REC'D BY REGISTRAR <b>Charles Judge</b>			
ADDRESS <b>Laurel Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



1  
M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2  
T

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 04010 CERTIFICATE OF DEATH 04000									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Tennessee</b> b. COUNTY <b>Elizabethton</b> 79-3				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elizabethton</b>				
c. LENGTH OF STAY IN 1b <b>69 days</b>					d. STREET ADDRESS <b>Route #4</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>									
3. NAME OF DECEASED (Type or print) <b>Mary Ann Livingston</b>			First Middle Last		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1966</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12 September 1907</b>		9. AGE (In years last birthday) <b>58 yrs.</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>6</b> Days <b>18</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Not employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Livingston</b>					14. MOTHER'S MAIDEN NAME <b>Alice Eliza Humphrey</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record, The Clinical Center, Bethesda, Maryland</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia due to Escherichia Coli</b> 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Chronic Lymphocytic Leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 years</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>20 January, 1966</b> , to <b>30 March, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 30, 1966</b> , and that death occurred at <b>7:35M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Robert C. Gallo, M.D.</b>					22b. DATE SIGNED <b>30 March 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert C. Gallo, M.D.</b>		
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
<b>Burial-transit 3-30-66</b>					<b>Livingston Family Cem.</b>		<b>Elizabethton, Tenn.</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Maryland</b>					25a. REC'D BY REGISTRAR <b>APR 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1070

1070

Montgomery

Tennessee

Belmont

69 days

Livingston

The Clinical Center, Belmont, Tennessee

Livingston

and

only

March 30 1960

Female

14 September 1907

0

11

Homemaker

Not employed

Tennessee

U.S.A.

John Henry Livingston

Alice Eliza Livingston

None

None

The Clinical Center, Belmont, Tennessee  
The Medical Center

2 days

agreement due to permanent loss

Chronic lymphatic leukemia

2 years

30 January 1960

March 30

1960

The Clinical Center, Belmont, Tennessee

Department of Health, Belmont, Tennessee

Robert G. Davis, M.D.

APR 1 1960



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
040017 CERTIFICATE OF DEATH 04001

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>		16 - 2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>				d. STREET ADDRESS <u>1102.2 Cherry Hill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edna Beatrice Lodge</u>				4. DATE OF DEATH <u>3-13-1966</u>		9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-4-85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Van Camp</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>		Address.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>March 10, 1966</u> , to <u>March 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 13, 1966</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wayne E. Clickfield</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>WAYNE E. CLICKFIELD</u>		22d. ADDRESS <u>6826 Ryggs Rd Hyatts Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Church</u>		23d. LOCATION (City, town or county) (State) <u>Darnestown Md.</u>	
24. FUNERAL DIRECTOR <u>Ed. D. Dutton</u>		ADDRESS <u>316 E. Darnestown Rd Darnestown, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04012		04002	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6701 Brablet Blvd.</u>		d. STREET ADDRESS <u>6701 Brablet Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine Stoney LOKER</u>		4. DATE OF DEATH <u>March 21 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1901</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR <u>Months</u> <u>Days</u> IF UNDER 24 HRS. <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DONZEL STONEY</u>		14. MOTHER'S MAIDEN NAME <u>EMMIE SHARRATT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-7077</u>	
17. INFORMANT <u>Capt. A.M. LOKER (See Item #2)</u>		Address <u>(See Item #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 143X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Floor of Mouth</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1940</u> , 19 <u>64</u> , to <u>3/21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> , 19 <u>66</u> , and that death occurred at <u>1:40</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Edgar H. Levin</u>		22b. DATE SIGNED <u>3/21/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDGAR H. LEVIN</u>		22d. ADDRESS <u>8218 Wisconsin Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3-22-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>VAR 24 1966</u>	
5130 Wisc. Ave. N.W. Wash. D.C.		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1945

1945

Handwritten notes and signatures, including a large 'S' and 'J'.

Handwritten text, possibly a date or reference number.

Handwritten text at the bottom of the page, including a date and a signature.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

04018

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04003

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN ID <b>10 1/2</b> hours					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				e. STREET ADDRESS <b>% Malinda Russell</b>					
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>(NMN)</b> Last <b>Long</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>19 66</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 23, 1897</b>			
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>Issac Long</b>				14. MOTHER'S MAIDEN NAME <b>Ida Delaney</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes 11-2-18 to 1-11-19</b>				16. SOCIAL SECURITY NO. <b>11-2-18 to 1-11-19</b>					
17. INFORMANT <b>Hospital Records</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Diaphragmatic Myocardial</b> <b>4201</b> DUE TO (b) <b>Infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Coronary Artery Heart Disease.</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus - Bilat. Gangrene of feet</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Beldon R. Reap</b>				M.D. <b>Beldon R. Reap, M. D.</b>				22. DATE SIGNED <b>March 4, 1966</b>	
EXAMINER'S NAME (Type) <b>Beldon R. Reap, M. D.</b>				DEPUTY MEDICAL EXAMINER <b>Wheaton</b>				Address (Street, city, town, or county) <b>Wheaton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>County Home.,</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Md.</b>	
24. FUNERAL DIRECTOR <b>Robert L. Sumner</b>				ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

30120

8101

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-01 BY 1043

EXCEPT WHERE SHOWN OTHERWISE

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-01 BY 1043

EXCEPT WHERE SHOWN OTHERWISE

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DATE 10-10-01 BY 1043



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04014

04064

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47-3 d. STREET ADDRESS <u>4542-Harrison St. NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Helen</u> Middle <u>E.</u> Last <u>Lowry</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/181</u> 9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>secretary Treas</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Etwan Fertz. Co.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina, U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>Christopher Gardner</u> 14. MOTHER'S MAIDEN NAME <u>Louise C. Rogers</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>248-07-1039</u> 17. INFORMANT <u>Mrs. Louise S. Pinkney</u> Address _____	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>arteriosclerotic hypertension heart disease</u> DUE TO (c) <u>Unknown &amp; diabetes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> , 19 <u>59</u> to <u>3-11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-11</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Sarah E. Glover</u> 22c. PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u>		22b. DATE SIGNED _____ 22d. ADDRESS <u>10128 CEDAR LAKE Kensington Md</u> M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL CREMATION, <u>Burial</u> (Specify)	23b. DATE THEREOF <u>3/14/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) <u>Washington, D. C.</u> (County) _____ (State) _____
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u> ADDRESS <u>Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1966</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on an event, within 72 hours after death.

2012-11

1020

FOR STATE  
 HEALTH DEPT.

04015

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04005

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>15-1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>MONTGOMERY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM</b>				d. STREET ADDRESS <b>8722 MANCHESTER RD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY CATHERINE LYONS</b>		4. DATE OF DEATH Month <b>3</b> Day <b>21</b> Year <b>1966</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		9. AGE (In years last birthday) <b>58</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
12. FATHER'S NAME <b>Phillip Barnett</b>		13. MOTHER'S MAIDEN NAME <b>Jo Anna Terry</b>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		15. SOCIAL SECURITY NO. <b>210-10-7012</b>		16. INFORMANT <b>CHART</b> John B. Lyons-2212 Colston Dr	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive subarachnoid hemorrhage</b> <b>9040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>due to ruptured intracranial aneurysm.</b> DUE TO (c)		18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Deceased fell in bedroom at home injuring head</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased fell in bedroom at home injuring head</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:00</b> <b>3/21</b> <b>1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Silver Spring Montg. Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE <b>Belden R. Read</b>		21. EXAMINER'S NAME (Type) <b>BELDEN R. READ, M.D.</b>		22. DATE SIGNED <b>March 22, 1966</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/25/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Md.</b>		24. FUNERAL DIRECTOR <b>Tyson Wheeler 1331 Rockville Pike, Rock.</b>		25a. REC'D BY REGISTRAR <b>MAR 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04016

04006

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in lb <u>3 hrs. 40 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>7 Walker Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Christine</u> First Middle <u>Madine</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bliss VanDenHeuvel</u>		14. MOTHER'S MAIDEN NAME <u>Heneretta Deremus</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no) or (unknown)		16. SOCIAL SECURITY NO. <u>217-32-4916</u>	
17. INFORMANT <u>Hilda Young-daughter</u>		Address <u>13 Hutton St. Gaithersburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction Recent and remote</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>43</u> to <u>3/26</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>3/26</u> , 19 <u>66</u> , and that death occurred at <u>7 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Luciano L. Leal</u>		22b. DATE SIGNED <u>3/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Luciano L. Leal</u>		22d. ADDRESS <u>Gaithersburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/29/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg, Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Emory B. Farnier, Gaithersburg, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 29 1966</u>	

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04017

Item 5 Film C374 5/11/66 mb

04007

1. PLACE OF DEATH a. CDUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> <u>16-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>12418 Melody Turn</u>			
3. NAME OF DECEASED (Type or print) First <u>—</u> Middle <u>—</u> Last <u>Mandala</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6, 1966</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Andrew Mandala</u>				14. MOTHER'S MAIDEN NAME <u>Ruby Nan Gutterson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>776 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-6</u> , 19 <u>66</u> , to <u>—</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard J. Hollander</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Richard J. Hollander, M.D.</u>				22d. ADDRESS <u>1110 Spring Street, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler 1331 Rockville Pike, Rockville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Richard J. Hollander, N.D., 1110 Spring Street, Silver Spring, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**04018**

## CERTIFICATE OF DEATH

**04008**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 15-1</u> d. STREET ADDRESS <u>415 SILVER SPRING AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>GERTRUDE</u> Middle <u>C</u> Last <u>MAO</u>			<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>11</u> Year <u>1966</u>				
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-20-1905</u>	<b>9. AGE</b> (In years last birthday) <u>60</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>- - -</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>China</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>China</u>	
<b>13. FATHER'S NAME</b> <u>Harvey Chen</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Julia Howe</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Edward K. Mao, Same as Item #2 above</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, RECENT AND OLD</u> <u>4201</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>ATHEROSCLEROSIS, GENERALIZED, SEVERE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 YRS</u> <u>7 YRS</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>DIABETES MELLITUS</u>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>MAR. 9</u> , 19 <u>64</u> , to <u>MARCH 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>MARCH 10</u> 19 <u>66</u> , and that death occurred at <u>6:40 AM</u> , from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Robert G. Angle</u>			<b>22b. DATE SIGNED</b> <u>MAR. 11, 1966</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Robert G. Angle</u>		
<b>22d. ADDRESS</b> <u>5009 Del Ray Ave. Bethesda, Md.</u>			<b>22e. MED. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-14-1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cemetery</u>			
<b>23d. LOCATION</b> (City or Town) (County) (State) <u>Washington, D. C.</u>		<b>24. FUNERAL DIRECTOR</b> <u>Joseph Gawler &amp; Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>					
<b>25a. REC'D BY REGISTRAR</b> <u>MAR 17 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04019

04009

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> c. LENGTH OF STAY IN lb <u>26 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47-3</u> d. STREET ADDRESS <u>6817 Georgia Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anne</u> First Middle Last <b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>29</u> Year <u>1966</u>				<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12/14/03</u> <b>9. AGE</b> (In years lost birthday) <u>62 yrs.</u> <b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Bookkeeping</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____ <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Wash. D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>				<b>13. FATHER'S NAME</b> <u>unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Bertha Bauschelle</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>unknown</u> <b>17. INFORMANT</b> Address <u>9212 Adelphi</u> <u>Lydia M. Richards Road. Adelphi Md.</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>probable Cerebral Hemorrhage</u> <u>443x</u> DUE TO (b) <u>Hypertensive Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 d.</u> <u>10 yrs</u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/28</u> , 19 <u>66</u> , to <u>3/29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> , 19 <u>66</u> , and that death occurred at <u>5:45 PM</u> , from causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>Richard H. Pollen</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>3/29/66</u> m.d.					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>RICHARD H. POLLEN</u>				<b>22d. ADDRESS</b> <u>10511 SUMMIT AVE KENSINGTON, MD.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2 April 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>			<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Suitland, Md.</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>AC 20012</u> <u>Funeral Home 7406 Sh. Ave. N.W.</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>APR 1 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04020

04010

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Manor				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5100 Brookeway Dr., Bethesda e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Uarda B. MARSH		<b>4. DATE OF DEATH</b> Month Day Year Mar 28 1966		<b>5. SEX</b> F		<b>6. COLOR OR RACE</b> Cauc.		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> May 28, 1889		<b>9. AGE</b> (In years last birthday) 76 yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min. 10 0			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Home				<b>11. BIRTHPLACE</b> (County & State, or foreign country) Ohio				<b>12. CITIZEN OF WHAT COUNTRY?</b> USA					
<b>13. FATHER'S NAME</b> Chester E. Bryan						<b>14. MOTHER'S MAIDEN NAME</b> Myra Dailey											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) No				<b>16. SOCIAL SECURITY NO.</b> 271-30-4485D				<b>17. INFORMANT</b> 5100 Brookeway Dr. C.B. Robertson Bethesda, Md.									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible coronary insufficiency acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)														<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. 19				<b>20d. INJURY OCCURRED</b> While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from Feb 1965 to March 1966, that (I) (we) last saw the deceased alive on March 19, 1966, and that death occurred at 7 A.M. from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> Marvin Wadler										<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/>		<b>MED. DIRECTOR</b> <input type="checkbox"/>		<b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> Mar 28, 1966	
<b>22c. PHYSICIAN'S NAME (Type)</b> MARVIN WADLER										<b>22d. ADDRESS</b> 8218 Wisc. Av. Bethesda, Md.							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial-Transit 3/28/66				<b>23b. DATE THEREOF</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> Kirkwood Cemetery				<b>23d. LOCATION</b> (City, town or county) (State) London, Ohio					
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> Robert A. Pumphrey										<b>ADDRESS</b> Bethesda, Md.				<b>25a. REC'D BY REGISTRAR</b> MAR 30 1966		<b>25b. REGISTRAR'S SIGNATURE</b> Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DATE OF BIRTH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film G376 125166											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04021 04011											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>						c. LENGTH OF STAY IN lb					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS <b>Olney</b> <b>Rt. 97</b>					
3. NAME OF DECEASED (Type or print) <b>GEORGE R. MARSHALL</b>						4. DATE OF DEATH <b>3 6 19 66</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/9/24</b>		9. AGE (In years last birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR <b>19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Montg. Co. Sch. Brd.</b>		11. BIRTHPLACE (State or foreign country) <b>Olney</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Theodore Marshall</b>						14. MOTHER'S MAIDEN NAME <b>Lulu Bowie</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>						16. SOCIAL SECURITY NO.		17. INFORMANT <b>Brother-Joseph Marshall; Olney, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple extreme internal injuries with</b> <b>8164</b> DUE TO <b>massive secondary hemorrhage.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20e. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Deceased, driver, in head-on collision with another motor vehicle.</b> 20c. TIME OF INJURY Month, Day, Year <b>7:05 p.m. 3/6 66</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b> 20f. (City or town) <b>Silver Spring</b> (County) <b>Montg.</b> (State) <b>Md.</b> 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Belden R. Reap, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Belden R. Reap, M. D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Wheaton, Maryland</b> 22e. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>3/11/66</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b> 22d. LOCATION (City, town, or country) (State) <b>Mt. Zion, Md.</b> 23. FUNERAL DIRECTOR <b>Robert L. Swenden</b> ADDRESS <b>Rockville, Md.</b> 24e. REC'D BY REGISTRAR <b>MAR 14 1966</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

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CERTIFICATE OF DEATH

04022

04012

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3111 Rolling Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Leon</u> Middle <u>C</u> Last <u>Marshall</u>				4. DATE OF DEATH Month <u>mar</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/79</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Johns Hopkins - American University</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Zanesville, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wesley Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Tanner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-4145</u>		17. INFORMANT <u>(daughter)</u> Address <u>Rockville</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, terminal</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephrosclerosis, advanced.</u> DUE TO (c) <u>Arteriosclerosis, generalised</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus, acute</u> <u>Rheumatoid arthritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , to <u>March 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 17, 1966</u> , and that death occurred at <u>4:45 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				22d. ADDRESS <u>4740 Chevy Chase Dr</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>3/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEES CREMATORY</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON D.C.</u>	
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME</u> ADDRESS <u>300 4th ST. N.E.</u>				25a. REC'D BY REGISTRAR <u>MAR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04014

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>Doughoregan Manor</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Bobby Lee Mathews</b>				4. DATE OF DEATH <b>March 30 1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 30, 1966</b>	
9. AGE (In years last birthday) <b>1</b> yrs. <b>50</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>as above</b>				13. FATHER'S NAME <b>Herman Perry Mathews</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Ellen Brown</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Father</b>			
16. SOCIAL SECURITY NO. <b>as above</b>				17. INFORMANT <b>as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary atelectasis; Diaphragmatic</b> <b>7620</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hernia with abdominal contents in left chest.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Tazwell</b>				20g. (County) <b>Virginia</b>			
20h. (State) <b>Virginia</b>				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>March 30, 1966</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4-1-1966</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Family</b>				22d. LOCATION (City, town, or county) <b>Tazwell</b>			
22e. (State) <b>Virginia</b>				23. FUNERAL DIRECTOR <b>F.C. Higginbotham, Ellicott City, Md</b>			
24a. REC'D BY REGISTRAR <b>APR 1 1966</b>				24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and up any event within 72 hours after death.

Handwritten notes and stamps, including "Bobby" and "Perry".

Vertical handwritten text, possibly a list or index.

Extensive handwritten notes and stamps on the left side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04025 04015											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharon 75-3					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland						d. STREET ADDRESS 731 Service Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Grace Charlotte Mathieson						4. DATE OF DEATH Month Day Year March 16 19 66					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 September 1913 52 yrs.		9. AGE (in years last birthday) Months Days Hours Mln. 6 0		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Byron Hodgson						14. MOTHER'S MAIDEN NAME Minnie Moon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 211-07-9627		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 Sub-arachnoid hemorrhage 2043 DUE TO (b) Gram negative septicemia DUE TO (c) Acute Lymphocytic Leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (this hospital) attended the deceased from March 7, 19 66, to March 16, 19 66, that (we) last saw the deceased alive on March 16, 19 66, and that death occurred at 8:15M, from the causes and on the date stated above. 22a. SIGNATURE Herman A. Godwin, Jr. 22b. DATE SIGNED 16 March 1966 M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Herman A. Godwin, Jr., M.D. 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit				23b. DATE THEREOF 3-16-66		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem. Park				23d. LOCATION (City, town or county) (State) Mercer County, Penna.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY Bethesda, Maryland						25a. REC'D BY REGISTRAR MAR 18 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge			

552

From the above we can see that the

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1. *Chrysomelids* (100%)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery County</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b <i>9 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>6600 Tulip Hill Terrace</i>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i> d. STREET ADDRESS <i>6600 Tulip Hill Terrace Wash. D.C.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <i>Mary Ladwina McCarran</i>			<b>4. DATE OF DEATH</b> <i>Mar 25 1966</i>			<b>5. SEX</b> <i>F</i>			<b>6. COLOR OR RACE</b> <i>W</i>		
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <i>Aug 31, 1906</i>			<b>9. AGE</b> (In years last birthday) <i>59</i> yrs.			<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Teacher</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Religious - Education</i>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Utah</i>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>				<b>13. FATHER'S NAME</b> <i>Patrick Anthony McCarran</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Martha Harriet Weeks</i>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>NO</i>				<b>16. SOCIAL SECURITY NO.</b> <i>579-54-4903</i>				<b>17. INFORMANT</b> <i>Sister Margaret Patricia Samparobin</i>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i> (b) <i>Carcinoma of Ovaries</i> (c) <i>Carcinomatosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year <i>Home and 3:45 p.m. Mar 25 1966</i>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>				<b>(County)</b>				<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>Aug 1964</i> , <b>to</b> <i>Mar 25, 1966</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>Mar 24 1966</i> , <b>and that death occurred</b> <i>3:45 P.M.</i> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <i>Paul D. Neslen</i>						<b>22b. DATE SIGNED</b> <i>25 Mar 66</i>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <i>Earl D. Neslen M.D.</i>						<b>22d. ADDRESS</b> <i>4715 Mass. Ave. N.W.</i>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Removal</i>				<b>23b. DATE THEREOF</b> <i>3-28-1966</i>				<b>23c. NAME OF CEMETERY OR CREMATORY</b>			
<b>23d. LOCATION</b> (City, town or county) <i>Reno, Nevada</i>				<b>(State)</b>							
<b>24. FUNERAL DIRECTOR</b> <i>Joseph Gawler's Sons, Inc.</i>						<b>25a. REC'D BY REGISTRAR</b> <i>MAR 29 1966</i>					
<b>25b. REGISTRAR'S SIGNATURE</b> <i>J. Charles Judge</i>											

George Washington Jones, M.D.

Removed

Bartholomew M.D.

John A. M.D.

Bartholomew M.D.

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Bartholomew M.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) M. STATE <b>Maryland</b> D. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westmoreland Hills</b>					c. LENGTH OF STAY IN 1b <b>- -</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5324 Portsmouth Road</b>					e. STREET ADDRESS <b>5324 Portsmouth Road</b>				
3. NAME OF DECEASED (Type or print) First <b>Sue</b> Middle <b>Cook</b> Last <b>McClure</b>					4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-14-1893</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Ernest Cook</b>					14. MOTHER'S MAIDEN NAME <b>Julia West</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>- - -</b>		16. SOCIAL SECURITY NO. <b>223-05-0769</b>		17. INFORMANT <b>Dr. Wm. W. McClure</b>		Address <b>Road. Md. 5324 Portsmouth</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of sigmoid colon</b> <b>1533</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>K metastases</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 1965, to <b>3/23</b> , 1966, that (I) (we) last saw the deceased alive on <b>3/22</b> , 1966, and that death occurred at <b>4:18</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>W. R. Moses</b>					22b. DATE SIGNED <b>3/23/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>William R. Moses, M.D.</b>					22d. ADDRESS <b>1835 Eye St. N.W. Washington, DC.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE THEREOF <b>3-25-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hollywood Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Richmond, V a.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SONS, INC.</b> <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>					25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

04011

01021

Montgomery

Lyland

Montgomery

Westmoreland Hills

Westmoreland Hills

5504 Fortemount Road

5504 Fortemount Road

March 25,

McClure

Cook

Eye

73

3-14-1963

x

Sample 1111

U.S.A.

Lyland

Housesville

John West

John West

Head, N.Y.

5504 Fortemount Road, N.Y. 10011

5504 Fortemount Road, N.Y. 10011

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MAR 28 1963

MAR 28 1963

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04028

04018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>1 year</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Chevy Chase Nursing Home</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2801 Quebec St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Lillian M. McDevitt</b>				<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>12</b> Year <b>1966</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 31, 1876</b>		<b>9. AGE</b> (In years last birthday) <b>89</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk - Retired</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U. S. Govt.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Kansas</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>John McDevitt</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Jane Young</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Miss Marie McAlear</b>		Address <b>2801 Quebec NW. Wash. D. C.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <b>Generalized Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3/4/66</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes Mellitus, Peptic Ulcer</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>10/1</b> , 19 <b>64</b> to <b>3/12</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/11</b> , 19 <b>66</b> , and that death occurred at <b>3:30</b> P.M. from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <b>Roger S. Williams</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>3/12/66</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>R.S. WILLIAMS</b> M.D.				<b>22d. ADDRESS</b> <b>35 N.Y. AVE N.W.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>March 15, 1966</b>		<b>23c. NAME OF CEMETERY</b> <b>St. Ann's</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Providence, R. I.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F.J. Collins</b> ADDRESS <b>F.J. Collins, 3821-14th St. N.W. Wash. DC</b>				<b>25a. REC'D BY REGISTRAR</b> <b>MAR 15 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04019

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>S., Md.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home (901 Arcole Ave.)</b>		d. STREET ADDRESS <b>9400 Crosby Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Thomas</b> Last <b>McIntyre</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Caus.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/19/1877</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>18</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clerk</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Bowling Green, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Walker</b>		14. MOTHER'S MAIDEN NAME <b>Selby Harvey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-44-6539</b>	
17. INFORMANT <b>Robt. V. McIntyre</b>		Address <b>9400 Crosby Rd. Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cerebral thrombosis</b> DUE TO <b>3321</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> , 19 <b>March 7</b> , 1966, that (I) (we) last saw the deceased alive on <b>March 7</b> , 1966, and that death occurred at <b>5:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Bennet A. Porter, Jr., M.D.</b>		22b. DATE SIGNED <b>March 7, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bennet A. Porter, Jr., M.D.</b>		22d. ADDRESS <b>9301 Colesville Rd., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/10/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
25a. REC'D BY REGISTRAR <b>OAT MAR 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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• *Journal of Management Education* 25(1): 10-11

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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04030

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04020

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp</u>		d. STREET ADDRESS <u>1220 Tanley Road</u>	
3. NAME OF DECEASED (Type or print) <u>Lucile Wilson McLean</u> First Middle Last		4. DATE OF DEATH <u>March 4</u> Month Day Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-98</u>
		9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Washington State</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Jackson Wilson</u>	
14. MOTHER'S MAIDEN NAME <u>Sara Wilson STERNER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William R. McLean - husband</u> Address <u>1220 Tanley Rd., S.S. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive subarachnoid and intraventricular</u> DUE TO (b) <u>hemorrhage.</u> DUE TO (c) <u>330X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>March 5, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>March 9, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George's Co., Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25d. REC'D BY REGISTRAR <u>MAR 10 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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Wm. L. G. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04031											
04021											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>2605 ELNORAST. WHTN. HILLS</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>CORINNE M. MEABON</b>			4. DATE OF DEATH Month <b>3</b> - Day <b>15</b> Year <b>1966</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>7-21-78</b>			9. AGE (In years last birthday) <b>87</b> yrs.			IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b> Hours <b>15</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Rufus Guild</b>						14. MOTHER'S MAIDEN NAME <b>Frances Weed</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Thelma M. Birthel S. S., Md.</b> Address <b>2605 Elнора St.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Mesenteric infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonitis, rt. lower lobe</b> (c) <b>Arteriosclerotic cardiovascular disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> , to <b>March 15, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 15, 1966</b> , and that death occurred at <b>6:50 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Raymond Bradshaw</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/15/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Raymond Bradshaw</b>						22d. ADDRESS <b>345 University Blvd., S. S., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>March 19, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Highland Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Casper, Wyoming</b>			
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>						25a. REC'D BY REGISTRAR <b>VAR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**04032**

**CERTIFICATE OF DEATH**

**04022**

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>38 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15-1 d. STREET ADDRESS <u>330 West Edmonston Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bonnadale</u> First <u>Mehok</u> Middle <u>Mehok</u> Last <b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>		<b>4. DATE OF DEATH</b> <u>3-4</u> 19 <u>66</u> <b>8. DATE OF BIRTH</b> <u>8/9/47</u> 18 <b>9. AGE</b> (In years last birthday) <u>18</u> yrs. <b>11. BIRTH PLACE</b> (County & State, or foreign country) <u>U.S.A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John Mehok</u> <b>14. MOTHER'S MARRIED NAME</b> <u>Dolly Smith</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>no</u> <b>17. INFORMANT</b> <u>Mother Dolly - same</u> Address <u>same</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u> 463X DUE TO <u>due to pulmonary emboli</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>due to thrombophlebitis, left leg</u> (c) <u>due to thrombophlebitis, left leg</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b> <b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>2/25</u> , 19 <u>66</u> , to <u>3/4</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>3/4</u> 19 <u>66</u> , and that death occurred at <u>9:30 A.M.</u> , from causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>J. R. Thistlethwaite</u> M.D. <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>J. R. Thistlethwaite</u> <b>22b. DATE SIGNED</b> <u>3/4/66</u> <b>22d. ADDRESS</b> <u>1746 K St. N.W. D.C.</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>3/7/66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gate of Heaven</u> <b>23d. LOCATION (City or Town) (County) (State)</b> <u>Silver Spring, Md.</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Tyson Wheeler</u> <b>ADDRESS</b> <u>1331 Rockville Pike, Rock., Md.</u> <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u> <b>DATE</b> <u>MAR 7 1966</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04033

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04023

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington Grove</i>		c. LENGTH OF STAY IN lb <i>7 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Ridge Road</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington Grove</i> <i>15-1</i>	
d. STREET ADDRESS <i>Ridge Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Thurston Byers</i> Middle <i>Miller</i> Last <i>Miller</i>		4. DATE OF DEATH Month <i>March</i> Day <i>26</i> Year <i>19 66</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>23 Aug 1892</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Committing magistrate</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Police Dept.</i>	
11. PLACE (County & State, or foreign country) <i>Williamsport, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Walker Miller</i>		14. MOTHER'S MAIDEN NAME <i>Leila Byers</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>WW II</i>		16. SOCIAL SECURITY NO. <i>223-38-1125</i>	
17. INFORMANT <i>Frances E. Miller</i>		Address <i>Ridge Road Washington Grove, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart</i> <i>4200</i> DUE TO <i>seizure - Azygic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Osteolytic Carcinoma - primary</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 1965</i> , to <i>3-26</i> , 1966, that (I) (we) last saw the deceased alive on <i>3-25</i> , 1966, and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Jack Schumacher</i>		22b. DATE SIGNED <i>3-26-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Jack Schumacher M.D.</i>		22d. ADDRESS <i>105 Russell Ave., Gaithersburg, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>30 March 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		25a. -REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <i>8434 Georgia Avenue Silver Spring, Maryland</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>98 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Campbell</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lynch Station</b> d. STREET ADDRESS <b>Route # 1, Box 123</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Ronald</b> Middle <b>Dave</b> Last <b>Mitchell</b>			4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 66</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 May 1953</b>	9. AGE (In years last birthday) <b>12</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Edwin Douglas Mitchell</b>					14. MOTHER'S MAIDEN NAME <b>Barbara Lee Powers</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland 20014</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Acute Myelogenous Leukemia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b> <b>24 Hours</b> <b>4 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Nov. 24</b> , 19 <b>65</b> , to <b>March 2</b> , 19 <b>66</b> , that <del>he</del> (we) last saw the deceased alive on <b>March 2</b> , 19 <b>66</b> , and that death occurred at <b>11:55</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Herman A. Godwin, Jr.</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED <b>2 March 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Herman A. Godwin, Jr., MD.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 4 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Montev</b>		23d. LOCATION (City, town or county) (State) <b>Bedford County, Virginia</b>			
24. FUNERAL DIRECTOR <b>C. H. Smith</b> ADDRESS <b>Maryland</b> <b>Warner E. Humphrey, Inc 8434-Ga. Ave. Silver Spring</b>					25a. REC'D BY REGISTRAR <b>DATE MAR 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04035

## CERTIFICATE OF DEATH

04025

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town</u>			
c. LENGTH OF STAY IN IB <u>2 days</u>				d. STREET ADDRESS <u>Kings Hill Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Santford</u> Middle <u>Perry</u> Last <u>Modlin</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>1966</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1893</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>21</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOBE &amp; OYE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BENDIX</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN E. MODLIN</u>				14. MOTHER'S MAIDEN NAME <u>MARY SHARPE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>EDWARD L. MODLIN - SON - SAME</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>							INTERVAL BETWEEN ONSET AND DEATH. <u>Days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral pneumonia; Metastatic carcinoma of prostate</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 1, 1965</u> , to <u>March 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 4, 1966</u> , and that death occurred at <u>4:00 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>George H. Mitchell</u>				22b. DATE SIGNED <u>March 4, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>GEORGE H. MITCHELL, M.D.</u>	
22d. ADDRESS <u>4890-BATTERY LANE, BETHESDA, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/7/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPHS MEMORIAL PARK</u>		23d. LOCATION (City or town) (County) (State) <u>SOUTH BEND, INDIANA</u>	
24. FUNERAL DIRECTOR <u>William M. Hyson</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. ADDRESS <u>Hyson's Funeral Home - 1300 N St., N.W.</u>				DATE <u>MAR 7 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04036

04026

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>B Chevy Chase Md.</u> d. STREET ADDRESS <u>3611 Thornapple St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Leu S. Mohler</u>			<b>4. DATE OF DEATH</b> Month <u>Mar.</u> Day <u>14</u> Year <u>1966</u>		
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 14, 1891</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months <u>9</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Property manager</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u>	
<b>13. FATHER'S NAME</b> <u>Edward Mohler</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> <u>WWI</u>			<b>16. SOCIAL SECURITY NO.</b> <u>578-07-6077</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma</u> DUE TO (c) <u></u>			<b>17. INFORMANT</b> <u>Hilda R. Mohler Chevy Chase, Md.</u> Address <u>3611 Thornapple St.</u> INTERVAL BETWEEN ONSET AND DEATH <u></u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Emphysema and congestive heart failure</u>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>	
<b>20f. (City or town)</b> <u></u>		<b>20g. (County)</b> <u></u>		<b>20h. (State)</b> <u></u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/11, 1959</u> <b>to</b> <u>present</u> <b>that (I) (we) last saw the deceased alive on</b> <u>3/14, 1966</u> <b>and that death occurred</b> <u>11:15</u> <b>M.</b> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>John B. Umhan</u>		<b>22b. DATE SIGNED</b> <u>3/14/66</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>John B. Umhan</u>	
<b>22d. ADDRESS</b> <u>8805 Con. Av. Chevy Chase Md.</u>		<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/17/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat'l Cem.</u>	
<b>23d. LOCATION</b> (City, town or county) <u>Arlington, Virginia</u>		<b>23e. (State)</b> <u></u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey Bethesda, Md.</u>		<b>24b. ADDRESS</b> <u></u>		<b>25. RECEIVED BY REGISTRAR</b> <u>MAR 16 1966</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>25c. (State)</b> <u></u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

Med. Examiner Notified signed Dr. Ball. 3-8-66

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04037 CERTIFICATE OF DEATH 04027

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring. 15-1</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>629 Sligo Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HENRY</u> First <u>Indore Moler</u> Middle <u>Moler</u> Last		4. DATE OF DEATH <u>3</u> Month <u>17</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/13/07</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supply Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Brunswick, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob H. Moler</u>		14. MOTHER'S MAIDEN NAME <u>Laure U. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>578-07-3663</u>	
17. INFORMANT <u>Henry Zecher</u> Address <u>501 McArthur Drive Rockville, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4200</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>KNOWN 2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CARCINOMA OF THE LUNG (BRONCHOGENIC)</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/16</u> , 19 <u>66</u> , to <u>3/17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> 19 <u>66</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Pollen</u> M.D.		22b. DATE SIGNED <u>3/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN MD</u>		22d. ADDRESS <u>10511 SUMMIT AVE, KENSINGTON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 20, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Park Heights Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Brunswick, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		OAT <u>MAR 21 1966</u>	

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FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04028

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>35 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Capital View Ave.</u>		d. STREET ADDRESS <u>9816 Capital View Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Coleman Dell Moore</u>		4. DATE OF DEATH <u>3</u> Month <u>8</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>ec. 31, 1893</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret/Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Limestone Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Morgan County, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Claude Moore</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Dell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>YES</u>	
17. INFORMANT <u>Joseph P. Moore</u>		18. ADDRESS <u>3262 Alpine Place Cincinnati, Ohio</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>330x Massive subarachnoid and intraventricular</u> DUE TO (b) <u>hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <u>March 9, 1966</u>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24. ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		25. ADDRESS (Street, city, town, or county) <u>8434 Georgia Avenue Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 11, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Plymouth, Indiana</u>
25a. REC'D BY REGISTRAR <u>MAR 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04039					04029						
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOLY CROSS</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> d. STREET ADDRESS <b>4219 KNOWLES AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>RACHEL W. MULLARKEY</b>			4. DATE OF DEATH <b>MARCH 11 1966</b>		9. AGE (In years last birthday) <b>92</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-8-74</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Balt. Md.</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13. FATHER'S NAME <b>John David Wheeler</b>					14. MOTHER'S MAIDEN NAME <b>Mary E. Turnbull</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-54 5157</b>		17. INFORMANT <b>Daniel P. Mullarkey</b> Address <b>9512 Calverton Rd Silver Spring, Md</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephrosclerosis</b> <b>446X</b> DUE TO (b) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Acute cholecystitis with cholelithiasis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>16 YRS</b> <b>20 YRS</b> <b>14 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (the hospital) attended the deceased from <b>3/1/66</b> , 19 <b>66</b> , to <b>3/11/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/10/66</b> , 19 <b>66</b> , and that death occurred at <b>8:05 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Henry C. Scruggs, M.D.</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3/11/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Henry C. Scruggs, M.D.</b>					22d. ADDRESS <b>5413 Cedar Lane, Bethesda, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bosque Bello Cem Bernardino Brook Fla</b>			23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <b>Charles Judge</b> <b>5001 W. Ave. Wash. D.C.</b>					25a. REC'D BY REGISTRAR <b>MAR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04030

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hospital</u>		d. STREET ADDRESS <u>Euclid Lane Box 462</u>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Elizabeth</u> Last <u>Mumford</u>		4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-1899</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Helena, Montana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Allen</u>		14. MOTHER'S MAIDEN NAME <u>Edith -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Box 462 Euclid Lane Silver Spring, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>accompanied by metastatic carcinoma of breast.</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u>		22. DATE SIGNED <u>March 2, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town, or county) <u>March 2, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 4 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAR 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04041					04031					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY in 1b <u>9 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>					d. STREET ADDRESS <u>8210 Moorland Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mary</u>		First	Middle	Last	4. DATE OF DEATH <u>3</u> <u>3</u> <u>19 66</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/81</u>	9. AGE (In years last birthday) <u>85 yrs.</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>66</u>		IF UNDER 24 HRS. Months <u>3</u> Days <u>19</u> Hours <u>66</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>C. Kerry, Ireland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Cornelius Carmody</u>				14. MOTHER'S MAIDEN NAME <u>Mary Shea</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Mary J. Whitecomb</u>		Address <u>Same as above</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> <u>leukemia</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis of ant. tibial artery</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		20g. (County)		20h. (State)						
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 28, 1965</u> to <u>March 19, 1966</u> that (I) (we) last saw the deceased alive on <u>3/16</u> <u>1966</u> , and that death occurred at <u>9:15 PM</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>RR Hottel</u>					22b. DATE SIGNED <u>3/14/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>RR Hottel</u>					22d. ADDRESS <u>1222 Monrovia St</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3-7-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet</u>		23d. LOCATION (city, town or county) (State) <u>Wash. DC</u>				
24. FUNERAL DIRECTOR <u>Thomas B. Standon</u>					ADDRESS <u>4748 Stisc Ave</u>		25a. REC'D BY REGISTRAR <u>1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04042 CERTIFICATE OF DEATH 04032

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> 15-1	
d. STREET ADDRESS <u>// Rt. 1, Box 138</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Elsworth</u> Last <u>Murray</u>		4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-16</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>15</u> Hours <u>15</u> Min. <u>45</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor of Lab.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.I.H. Bethesda, Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Columbus Murray</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Stewart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Hospital Admission Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuroblastoma (Prostate)</u> 1934 DUE TO (b) <u>retroperitoneal - (L.V.Q.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 15, 1966</u> to <u>3-10-66</u> , that (I) (we) last saw the deceased alive on <u>3-10-66</u> , and that death occurred at <u>11:40 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Jack Schumacher</u> 22c. PHYSICIAN'S NAME (Type) <u>Jack Schumacher, M.D.</u> 22b. DATE SIGNED <u>3-10-66</u> 22d. ADDRESS <u>Gaithersburg, Maryland</u> 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. REC'D BY REGISTRAR <u>Charles Judge</u> 22g. REGISTRAR'S SIGNATURE <u>Charles Judge</u> 23a. BURIAL, CREMATION, REMOVAL, OR OTHER <u>Burial</u> 23b. DATE THEREOF <u>3-14-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.</u> 23d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u> 24. FUNERAL DIRECTOR <u>George R. Brondau</u> ADDRESS <u>Rockville</u> 25a. REC'D BY REGISTRAR <u>MAR 15 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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